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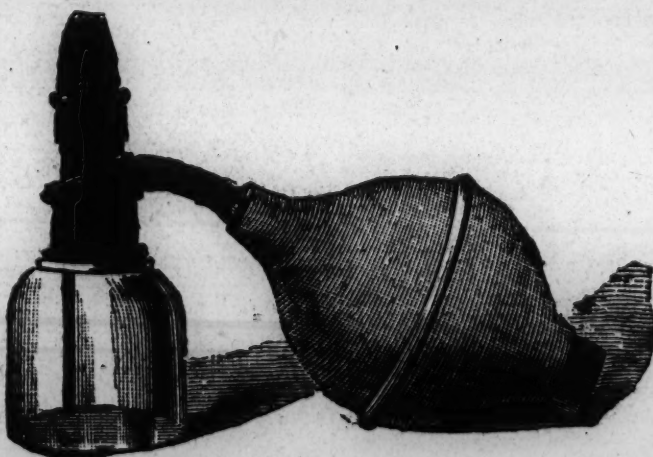


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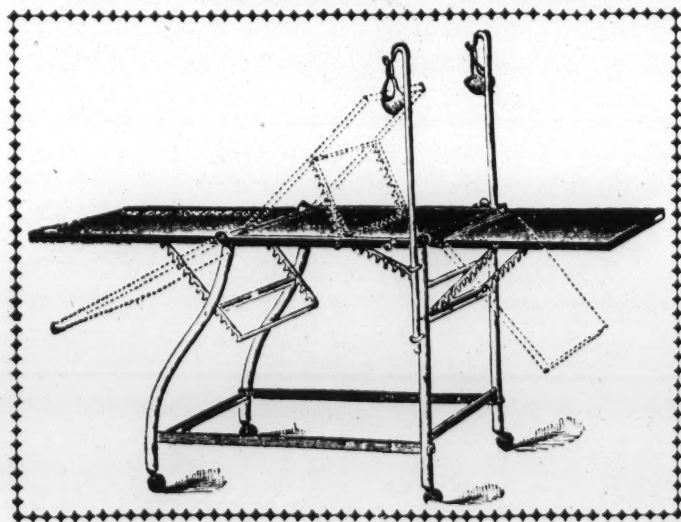
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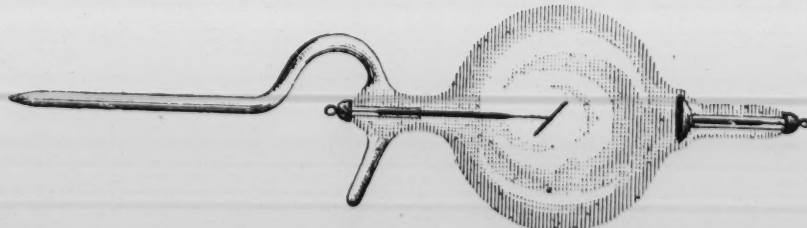
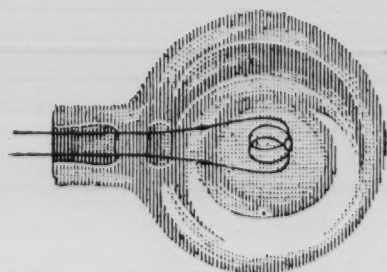
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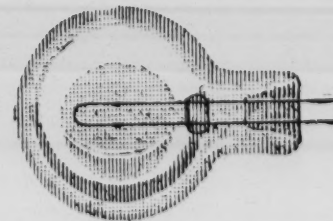
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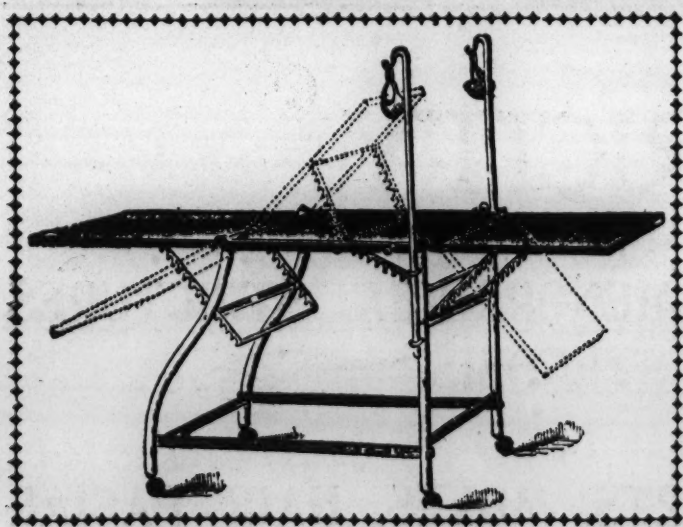
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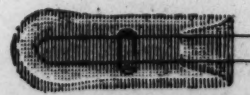
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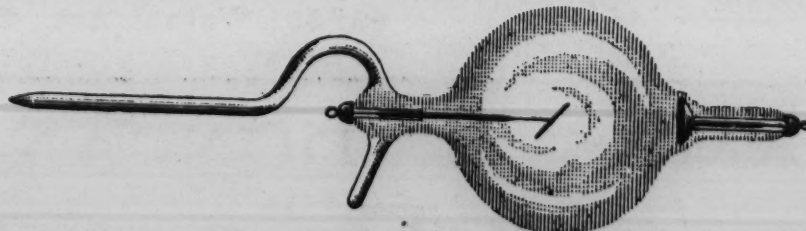
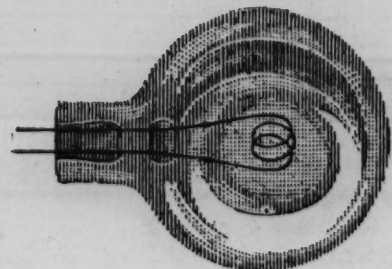
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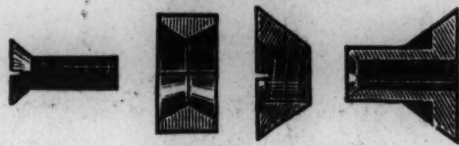
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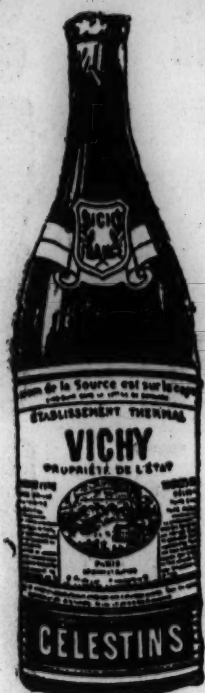
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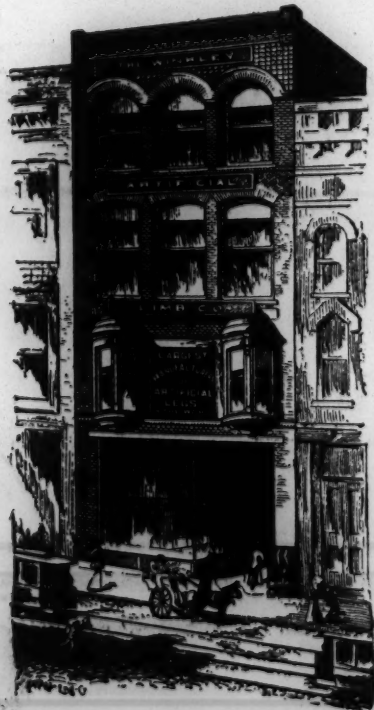
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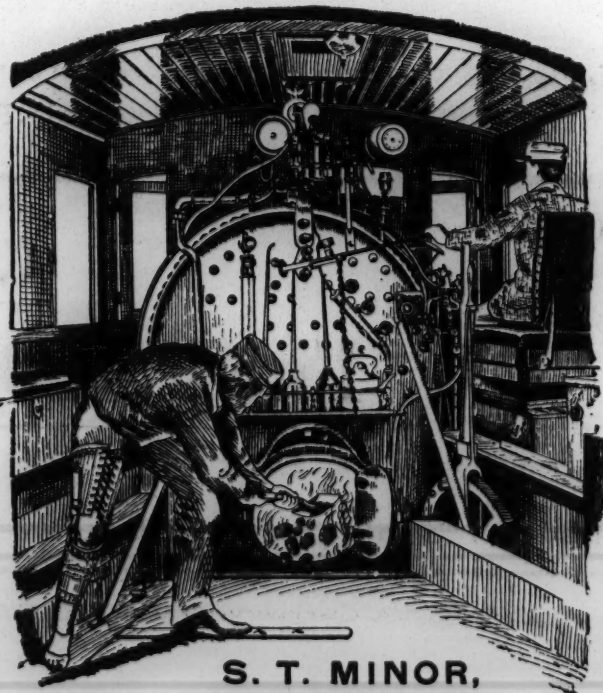
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VOLUME XIII.

SAN FRANCISCO, DECEMBER 15, 1899.

NUMBER 12.

STATE REQUIREMENTS FOR ADMISSION TO THE PRACTICE OF MEDICINE.

BY A. M. HENDERSON, M. D.,
SACRAMENTO, CAL.

Read before the California Northern District Medical Society.

A realization of the ideal in the practice of medicine demands the highest attainments of man, the most harmonious development of his threefold nature—the moral, mental and physical. While we cannot expect every physician to possess the ideal qualifications of his profession, as citizens we should certainly demand that the government require the physician to possess moral and educational qualifications proportionate to the development of the State and that provision be made for a proper test for such qualifications. As physicians we should jealously guard our fair name and assist in preventing the admission into our ranks of men whose future can only promise a degrading influence upon the reputation of the profession.

Sanitary medicine has become a most important factor in government in times of peace; war, an ally on whose influence may depend defeat or victory. For this reason, in the future, the government should protect itself against men who are not likely to advance with their profession. These are they who now announce to the public that typhoid fever is not conveyed by water; that antitoxin is a useless and dangerous remedy, or that appendicitis is never a surgical disease; of this type is the physician who a few months since said there was no diphtheria in a community where his own patients had died of what he called

"tonsillitis complicated by membranous croup." Such men exist in Northern California and so far as the State is concerned their opinion is as well indorsed as are the opinions of the most scientific of you.

With the advance that has been made in the science and art of medicine of late years, with the multiplication of detail and the difficulties of acquiring a thorough knowledge of the minutæ of the various branches of medicine, the man whose mind has not received the discipline equivalent to that obtained in the acquirement of a High School education, can scarcely be considered to possess the educational foundation requisite for the study of medicine. It is true that the applicant may have obtained its equivalent in the period of years devoted to business life. To such a man an injustice might be done, but not a serious one, as he would desire to obtain and would have no great difficulty in acquiring sufficient knowledge of the subjects taught in the High School to pass the requisite examination. A High School education is now more easily obtained than at any time during the past ten or twenty years, and in all walks of life there is demanded higher educational preparation.

The fact that Dr. A and Dr. B became eminent men in their profession, though they had practically no preliminary education, is not an argument against an educational requirement more exacting than had been demanded of them. Men of such ability would find no greater difficulty in overcoming such an obstacle, than they encountered in reaching special distinction in spite of a limited preparatory education. It is fair to assume

that Drs. A and B might have become much more eminent had they a proper preliminary education. On the other hand no account is taken of what became of Drs. X, Y and Z who have failed because of the lack of proper foundation for the study of medicine.

No uniform standard exists for admission to study in the various medical schools. Johns Hopkins has set an ideal example. Harvard now follows in announcing that after June 1, 1901, only persons having obtained degrees from recognized colleges will be admitted to study in the Harvard Medical School. Many require the equivalent of a High School education and insist upon obtaining it; many others announce this requirement, but have no system of examining applicants. These never reject an applicant and would consider it extremely shortsighted business policy to over scrupulously turn money away from their coffers for so slight a shortcoming. New schools are constantly being started and where they are poorly endowed or are established to boom the "professors" they must offer inducements to increase the student body. This leads to the acceptance of such applicants as might be refused admittance to other colleges. When Harvard and Johns Hopkins can limit their privileges to students four years in advance of High School graduates, it certainly is not unreasonable for the State to require that students must have a High School education before commencing the study of medicine. Such is the limit required by New York, New Jersey, Pennsylvania, and other eastern States and these States see that the requirements are fulfilled.

The present lax system occasionally does an injustice to the student. I know of two cases in two different schools where students were told after four years attendance that they could never expect

to obtain a medical degree from the college. In neither case, however, were the fees returned. Here the colleges were at fault, as the most superficial oral examination would have excluded either applicant from admission.

All the leading medical schools recognize the necessity of requiring four years for the study of medicine. Such colleges should be protected in the advance they are making by the State refusing the right to practise medicine to graduate from colleges not requiring so long a course. The term of study in European schools is still longer. The State should not accept the diplomas of medical colleges in lieu of conducting a personal examination, as the standards of colleges vary greatly, and it is a very difficult matter to draw the line. This is particularly so where the State has so little control over college methods, and where the college is dependent upon its student attendance for support.

In the following named States, practically no restriction is placed on the practice of medicine: Alaska, Arizona, Kansas, Michigan, Nevada and Wyoming.

In California, Kentucky, Nebraska, Ohio, South Dakota and Texas the presentation of a diploma of a recognized medical college to the State authorities is sufficient.

In Arkansas, Colorado, Connecticut, Illinois, Iowa, Missouri, New Mexico, Oklahoma, Rhode Island, Tennessee, Vermont, Indiana and Wisconsin, applicants are accepted on presentation of diplomas from certain schools, and all others are examined.

In the fourth group of States, that requiring an examination from all applicants, is to be found the majority of the States of the Union, namely Alabama, Delaware, District of Columbia, Florida, Georgia, Indian Territory, Louisiana,

Maine, Maryland, Massachusetts, Minnesota, Mississippi, Montana, New Jersey, New York, North Carolina, North Dakota, Oregon, Pennsylvania, South Carolina, Utah, Virginia, Washington, West Virginia, Idaho and New Hampshire.

The proposition is not an experiment, nor a theory; it is a thorough practical success, and this is emphasized by all the physicians in the States which have accepted it. It has improved and systematized the work of the medical schools. Instead of contesting to graduate the largest numbers, they strive for the record of having the least refused certificates by the State authorities. The present law of Pennsylvania went into effect March 1, 1894, since which time seven examinations have been held. One thousand two hundred and sixty-six applicants have been examined with 170 failures, an average percentage of 13.4. In Alabama from 1877 to 1896, 13.18 of applicants have been rejected. The percentage of rejection in Virginia has been 33. In Montana from 1893 to 1897, 33 per cent of all applicants were rejected. In one examination ten out of sixteen were rejected. What becomes of the 13 per cent that Pennsylvania and Alabama reject, of the 33 per cent to whom Montana and Virginia have refused admission, and of all those that New York, New Jersey and the other protected States disqualify? To them all, California, the grandest State in the Union, extends a welcome hand. That they have not come is only additional evidence that the Eastern States have wisely stamped the brand of ignorance upon them. We should no longer continue to be one of the so-called "dumping grounds for disqualified practitioners." In self-defense we must adopt a law as restrictive as those of the eastern States.

Several States, where such laws exist,

are now exchanging confidences and permitting licentiates of one State to practice in the other. Our State should assist in establishing a national standard of requirements and all the States should advance in unison until we shall be justified in demanding recognition in Europe or in resorting to reciprocal exclusion of European graduates from medical practice in this country. Such a consideration we cannot now with dignity ask, as none of the countries of Europe require less than five years of medical study.

The State should assume the responsibility of examining all applicants for admission to the practice of medicine. All matriculants in medicine should furnish evidence of having completed a High School course in an institution, the graduates of which are admitted to the university without examination, or of having passed the examination required for admission to the university. Evidence of an equivalent preliminary education should be required from all applicants having graduated in another State. Finally, the State should require that all applicants for examination present a diploma from a recognized medical school having a course of study of not less than four years, and the tests should be conducted by a board of examiners none of whose members should be engaged in teaching in any medical school.

829 J Street.

MEDICAL PRACTICE IN GUATEMALA.

BY W. H. WENTWORTH, M. D.,
SACRAMENTO, CAL.

Read before the Sacramento Society for Medical Improvement.

The Spanish people are by nature conservative, jealous and suspicious of all that is foreign. Add to this natural characteristic the fact that a large percentage of the foreign population of

Spanish America is made up either of those who have come thither for purposes of more or less unscrupulous gain, or of those who have left behind in their native land both name and fame, and it is not difficult to understand why an American's reception is unfriendly or even hostile. We are understood to be a people with no susceptibilities beyond the feverish eagerness for money, no national pride or loyalty, and a most overruling characteristic of low cunning, ever ready to hoodwink the virtuous and confiding Spaniard. And it must be confessed we have in a measure deserved our reputation in these countries. Our merchants have too often made them the dumping ground for cheap and fraudulent goods, our merchant vessels have been repeatedly fired upon with no adequate penalty to the offender, and the American population in Guatemala at least, is certainly of a nondescript character.

I was not surprised, therefore, to find the medical fraternity disposed to look at American credentials with an eye of very considerable suspicion. According to Guatemalan law, one may not practice medicine there without passing an official examination before the faculty of the national medical school in the City of Guatemala. This examination, however, is not by any means most difficult in the taking, but in the getting official permission to take it. You are made to feel that you are a most unwelcome intruder who would best take his departure from the country as soon as possible.

Formalities commence by the applicants visiting the college building and interviewing the secretary—if he can. I made some half-dozen visits extending over a week or ten days, before finding that gentleman. Formal application is received from the candidate on payment of \$100 and filing his credentials, attested

by the Guatemalan consul in San Francisco; after which, apparently, his case is completely forgotten. After waiting in vain perhaps three weeks or a month for a summons to be examined, another series of visits is made, resulting in a second interview with the secretary. Profuse and most ceremonious apologies are made—but, “the President is ill,” or “is out of town,” or “a vacation of a month has begun in the interval,” or “it is fiesta week and nothing can be done,” or, at the very most, all that can be done is to permit you to be examined on all the work taken in the full six years medical course of the college. I had the curiosity to figure up how much time this would take, and found that an examination every day for three and a half months would complete it. I concluded that the faculty was given to joking at times.

Satisfied at length that your case is not advancing, you begin to accumulate influence to bring pressure to bear upon the faculty to take up your application. I had the good services, which I happen to know were actively urged, of the American minister plenipotentiary, the American consul, the heads of several large mercantile establishments, and, finally, and what I believe proved most effective, of a kindly disposed and influential priest. He, apparently, worked upon President Barrios; for, after various other unavailing interviews on my part with different members of the faculty—as a result of which the difficulty finally simmered down into the statement that no examination could be given me because no cadaver for the operative work was obtainable—I received without warning the notification that the President had personally issued orders for the examination. Possibly they simply came to the conclusion that that would be the easiest way of getting

me out of the country. Notwithstanding the scarcity of cadavers, immediate notice came that my examination was set for the next day at the medical college. This, like all Spanish buildings, is a large rectangular structure of adobe, with stuccoed walls, built around a succession of paved courts. It has two stories, with broad double porticoes within, surrounding each court, and upon which all its apartments open. The public hospital is continuous with the college and of the same arrangement, which gives the offices and wards a broad, cool, shaded roominess that makes a very satisfactory hospital of it. They accommodate 1,500 patients.

The applicant for examination is ushered first into a hospital ward, where he is received by a committee of six of the faculty, and a crowd of students. One member of the committee takes him in charge, and, selecting some case in the ward, requires him to elicit a history of the case, make a physical examination, give a diagnosis and prognosis, and prescribe treatment, under the eyes of the committee, who do no questioning as yet, except such as to draw the applicant out. No criticism is offered. This process is repeated with two medical cases and a surgical case. Those assigned to me were a case of dysentery, a gonitis of tubercular origin, and a tubercular ostietis. This occupies half a day. On the afternoon of that day the applicant passes to the dissecting room of the college, where the same committee and the same crowd of students witness such operative work as is demanded. I was required to do a Chopart's and a Pirogoff's amputation of the foot, a tracheotomy and a resection of the superior maxilla. Student assistance is given the applicant, and, as before, no criticism of his work is made.

On the next day the proceedings take

place in the assembly hall of the college. A long room, large enough perhaps to accommodate 300, has a stage erected at the upper part, at the back of which, within a railed and canopied area, sit the committee in state. At one side of the stage, in a sort of pulpit, perhaps with the idea of making a better target, sits the unhappy applicant, to which post of honor he has been ushered with awful ceremony of ringing of bell and escort of the keeper of the door. The body of the room is pretty well filled with students much entertained, apparently, to see the Gringo frozen out, as their slang puts it. The applicant is then taken in hand by the members of the committee in turn, who proceed to quiz him upon his work in the wards and the operating room. All sorts of objections and criticisms, reasonable and otherwise, are urged, to cause him to defend his position. A further quiz upon obstetrics follows. Long before the end the unhappy applicant becomes well convinced that he hasn't a ghost of a chance of passing. Perhaps this mood is even a benefit to him, for, in the recklessness of assured defeat, a coolness comes that bolsters a man up wonderfully. After perhaps two hours of this sort of firing, there are other bell-rings, exits and entrances, and the committee, having balloted upon the candidate, decide perhaps more kindly than he had hoped; and he is sent again to interview the secretary—now a much changed individual in the degree of his friendliness—to the end of arranging with him a subject for a written thesis to be presented at a later date. For, behold you, all this is merely preliminary.

Having settled upon and composed a thesis, to which are appended some twenty or thirty subsidiary subjects, ranging over the whole field of medicine, materia medica, surgery, pathology,

obstetrics and the rest, upon which the applicant is to prepare himself to speak briefly, if asked, he prints his thesis and forwards copies to each of the committee and to the college officials, and some ten days later is again summoned to undergo his public examination, the former having been called the private one—private only in name, as we have seen. There is again the convention in the assembly room of the college—the room a little better filled than before, again the ceremonious entrance and ushering to the candidate's seat on the stage. But once the committee begins its questionings upon the thesis, the candidate becomes aware of a very different air about him, and it becomes shortly evident that this chapter of the proceedings is not much more than a formula. The ferocious virulence of the private questioning is changed for an air tempered largely with deference and Spanish courtesy, or at least mild difference of opinion, to which is added an evident desire to grind the man through as soon as possible. An hour of this is followed by another balloting, concerning the outcome of which the candidate has quite different hopes than before, and immediately the oath of fidelity to the Guatemalan medical institutions and ethics is administered, and the long road is finished.

My examination experiences, unpleasant as they were, were not, however, exceptionally severe, judging from the fact that the two applicants who preceded me and one examined immediately after me were rejected,—a state of affairs from which I took no credit to myself, but attributed purely to the weight of influence brought to bear by my friends. Practice comes readily—though the fees are small—about what ours are, not taking into account the low value of money—they are either cash or are

readily collectible. A population of 80,000, with some forty or fifty physicians, sends patients to your office every day and in increasing numbers. Surgical cases are particularly plentiful, for the Spanish physicians of the city are timid or unskillful operators. They are educated mainly in Paris, and well educated, as far as book knowledge goes; but the Spanish nature, or what not, brings about that result. For example, the crack Spanish surgeon of the city amputated a breast during my stay there, holding his bistoury, when not in use, between his teeth, and rinsing and reapplying a sponge that had fallen to the floor, and such like impossibilities.

In considering such an experience as this, it seems to me that not by any means all that I found new to me was to be condemned. As to what was worthy of condemnation, surely we do not find in Central America alone obstructive red tape and its various concomitants. But what I did find was, as far as the patients were concerned, an admirably conducted sanitary hospital, a strict six years' medical course in the college, in which, as far as I could judge, a good deal seems to be accomplished; at least, several senior internes, with whom in my interval of waiting I used to quiz, seemed well informed; and, lastly, a system of examination for license to practice, which, in spite of its absurd formalities and ceremonies, puts a bar of just requirement in the way of men of slipshod preparation—a bar of which we in America stand much in need.

Here the minimum requirement for the practice of medicine, in spite of plentiful legislation, seems hard to define, so microscopic is it. This, of course, is simply our way of expressing our opinion that the best way of suppressing ill-qualified practitioners is the *laissez faire* policy. Let them practice, we say

in effect, upon a confiding public until the people become convinced that these are not the right kind of doctors to hire. Perhaps it is more in harmony with democratic institutions to allow anybody who pleases to call himself a doctor and to practice, as being the best way of educating the public to see that they are fools who employ them. But our crowded and ever multiplying medical schools, our hordes of hand-to-mouth, half-educated young doctors, the apparently ever lessening degree of dignity in the profession and of public respect paid to it—these things are very prone to make us think with longing of some such stringent requirements for the practice of medicine as those I have detailed here.

1009 Seventh Street.

PLEURITIS.*

BY J. S. ADAMS, M. D., OAKLAND, CAL.

Read before the Alameda County Medical Association.

Pleuritis is an inflammation of the pleura, or lining, of the walls of the chest and external covering of the lungs. It may involve a large or small surface according to conditions, causes and time.

It is divided into acute, sub-acute, and chronic forms, also sero-fibrinous, and fibrinous or purulent.

As to the etiology, it may be idiopathic, caused by wet and cold; traumatic, or secondary to various diseases of adjacent viscera, such as pneumonia, phthisis, cancerous disease, or some morbid process such as infectious fevers, rheumatism, and organic diseases of the kidneys, etc.

Pathology.—At first the membrane is sticky and red, and covered with a thin

coating of lymph. Should the inflammation continue, the exudate may be sero-fibrinous, fibrinous, or purulent, and in greater or less quantity according to circumstances.

On account of adhesions, the effusion may occupy the whole lower portion of the chest, or be confined in one or more pockets. In the purulent form, the pus may be white, thin and odorless, or of a greenish yellow color, and more or less offensive in character, depending upon the various conditions and causes. An effusion of any kind which is not soon absorbed constitutes chronic pleurisy.

When we have pleurisy of a hemorrhagic character, it is generally the result of various cachectic conditions, such as tuberculosis, malignant disease, anemia, scurvy, etc.

Symptoms.—The symptoms of pleurisy are generally a sharp pain in the side affected and increased on full inspiration, chilliness, and cough which is short and dry, a pale and anxious countenance, and the patient generally inclines to lay on the side affected. The temperature generally varies from 101° to 103° or 4° , pulse from 90 to 120 per minute, sharp and jerky. When effusion begins there is generally less pain, but dyspnoea begins and develops rapidly with a sharp jerky breathing. At first the physical signs are less expansion on the diseased side on account of pain on respiration. Sometimes there is a friction fremitus on palpation, and a harsh friction sound on auscultation. This last is not always present. In the stage of effusion there is more or less immobility on the effected side, and sometimes bulging of the intercostal spaces. As the effusion progresses, the apex sound of the heart becomes changed if the effusion is confined to the left side of the chest, and is in considerable quantity; the entire heart sound may be on the

*This paper is the last work of Dr. Adams. It was completed the night before his death on his journey homeward from the Springs.

right side of the sternum. On percussion the dullness gradually rises as the effusion increases, and changes according to the position of the patient. Above the effusion, percussion gives a tympanitic sound, and the line of demarkation is easily made. Sometimes the effected side measures more than the sound one, but this cannot always be relied upon, as that often depends upon the occupation of the patient or a deformity developed in childhood. Sometimes after absorption of the effusion, more or less of the friction sound returns and may last for weeks.

Diagnosis.—In the first stage of this disease a correct diagnosis is not always an easy matter, owing to pre-existing conditions which may lead one astray unless every precaution is used in the examination. In pneumonia there is more or less severe chill, so on followed by a high fever, temperature ranging from 100° to 104° , more or less dyspnoea, and generally soon followed by rusty expectoration, crepitant rales on inspiration; then, or when a little further advanced, dullness which is changed by position, loud bronchial breathing, increased vocal fremitus and resonance, absence of displaced apex beat and bulging of affected side. Not infrequently when there is a pleuro-pneumonia, a combination of symptoms occurs which does not make it an easy matter to differentiate clearly at first. From intercostal rheumatism, or pleurodynia, no fever, more or less muscular tenderness, no friction sounds or effusion. In purulent effusion there is hectic fever, high and irregular sweats, chills, more or less anemia and the results of aspiration. In fibrinous pleurisy there is more or less severe and continuous pain, the dullness immobile, negative results on aspiration, and later there is frequently more or less retraction on the affected side. In

diaphragmatic pleurisy there is more or less pain under the margin of the ribs, increased by pressure; thoracic breathing, hiccough, extreme dyspnoea and tenderness over the phrenic nerve, which is found at the back of the neck between the roots of the sterno mastoid muscle. Tuberculosis is not an uncommon cause of pleurisy, and it may be primary or secondary to that disease. It frequently presents the same symptoms as the sero-fibrinous pleurisy, may be bilateral, develops insidiously, and the effusion is generally more or less bloody in character. The history of the case with these facts in mind will generally indicate a correct diagnosis.

Prognosis.—This depends greatly on the character and amount of the effusion and complications. In the sero-fibrinous pleurisy, ordinarily, the prognosis is good, but the tuberculosis and other complications that frequently occur should make us extremely careful in our examinations and obtaining the heredity and previous condition of the patient. In purulent effusion the prognosis is generally good, also, unless there is some organic complication. Where there is much exudate in the fibrinous form, more or less impairment of the functions of the affected side are almost certain to follow for a considerable time, and permanent adhesions generally follow in a greater or less degree.

Treatment.—In the treatment of this disease I may not be entirely in accord with what is considered the latest or most approved methods, but the rapid improvement in uncomplicated cases, with little or no effusion in the chest, when the patient is seen in the first stage of the disease, in short, in aborting the disease promptly, is the reason for following this course. In the adult, local bleeding by scarification and cups, until nearly or complete relief is obtained in

taking a long breath, followed by hot applications, is first in order. Complete rest and little light nourishment. If the bowels are not relaxed, and tongue coated, give two grains of calomel with soda bicarbonate every two or three hours until bowels are freely moved. If the temperature is 100° or over, five grains of phenacetine and sufficient codein, or some other anodyne, codein preferred, every two, three or four hours as is necessary to control pain and keep the temperature below 100° , until the disease yields completely. Always carefully examine the heart, and if there is organic disease or weak and irregular action, I always give from one-fourth to one-half ounce of whiskey, or some other diffusible stimulant with each dose of the antipyretic. By combining the stimulant in such cases, or if the patient is too weak and anemic, have never had any unfavorable aftereffects, and, from the experience gained, have come to the conclusion that in such cases it very materially aids in aborting the disease. In all cases, either dry or moist, heat should be constantly and carefully applied over the affected part, that which is the most agreeable to the patient.

If, on careful inquiry, there are any symptoms, or a probable history of malarial complication, decided doses of quinine, or sulph. cinchona should be administered two or three times in twenty-four hours, or as may be indicated. When the pain is very severe, hypodermic injections of morphia can be used as required. Phenalgin is highly recommended by some physicians, both as an anti-pain and fever medicine in such cases, in doses of from five to fifteen grains every two or three or four hours until fever and pain are relieved, but I have not had sufficient experience in its use to give an intelligent opinion. With adults and children, when there is a

strong prejudice, or the usual remedies produce a nauseating effect upon the patient, I frequently use the cyanide of mercury in small and oft repeated doses with excellent effect.

The application of adhesive straps to the affected side is a favorite remedy with some. Theoretically it works well, but practically, I have seldom been satisfied with the results. Iodine, mustard, blisters, and various other counter-irritants are also much used locally, but I fear we forget the recuperative power of nature, how kindly she assists us under all circumstances, and how persistently she endeavors to conceal our mistakes, and how often she succeeds, notwithstanding.

With children, for various reasons, cupping is generally objectionable, and gentle counterirritants, with hot poultices of linseed meal can be used with fairly good results. In proper doses have found the same remedies as safe and appropriate in the treatment of children as adults. In serous, or sero-purulent effusion, small blisters with potass.iodide, or syr.hydriodic acid combined with small doses of hydrarg. ioidid, or bin-iodid, given every three or four hours for its alterative effect.

When satisfied there is a pint or more effusion in either or both sides of the chest, I believe it should be promptly removed by aspiration, thus assisting nature to a speedy recovery, and also preventing irreparable injury to the parts involved.

When the effusion is sero-purulent or purulent and odorless, I always aspirate and use remedies the same as in serous effusion, and universally with good results unless there is some organic disease connected with it. If there is any doubt of effusion in the chest, it is good practice to explore every two or three days with a large sized hypodermatic

needle, and at different points, if necessary, if there is continued dullness over the middle or lower part of the chest. I have never had any ill effects from the punctures, and should the effusion be encysted, as is sometimes the case, and not found, and the patient drift into other hands, and the fluid be found afterwards, the results, in many ways, are liable to be unpleasant to the physician first in attendance, especially if the mistake be discovered by one whose conscience is somewhat elastic. The aspiration may be repeated one or more times if necessary, and generally with good results. If the effusion is sero-purulent, always use a large needle in aspirating and get all the fluid possible, unless persistent or painful coughing occurs.

Have found a diffusible stimulant of much benefit, given just before the operation, and if pain follows, an ordinary dose of phos. codein, or morphia, given hypodermatically, generally gives relief in a few minutes, but if not it can be repeated in half an hour with safety. Ethyl chloride externally, or twenty drops of a five per cent solution of eucain, hypodermatically at the point of puncture in aspirating, will make the operation a painless one or nearly so. The position of the patient has much to do in assisting to remove the most fluid.

HOSPITAL NOTES.

California Eye and Ear Hospital.

BY LOUIS C. DEANE, M. D.,
SURGEON TO THE HOSPITAL, ETC.

OPERATIVE TREATMENT OF HIGH MYOPIA.

The operative treatment in cases of high myopia is now generally recognized for its value.

The two methods used for removal of the crystalline lens are: By discission of the anterior capsule of the lens, with a knife needle, thus allowing the lens matter to come in direct contact with the aqueous humor to be ab-

sorbed, and by simple extraction of the lens, as is practiced for senile cataract.

The three general indications to be observed in operating for myopia are:

(1) It should not be practiced on cases under 13 O. D., and only in those where the correcting glasses give considerable discomfort.

(2) The operation is indicated especially in young adults.

(3) In cases of complicated myopia the operation is contraindicated as in eyes with choroidal changes in the region of the macula, progressive choroiditis, fluid vitreous, detached retina, etc.

Its advantages are, in short, to prevent the progressiveness of the condition and increase the field of vision and visual activity by precluding the use of powerful lenses.

L. C. DEANE.

HEADACHE AND SUPRA-ORBITAL NEURALGIA DUE TO NASAL SPUR.

I recently had two cases suffering more or less continuously from severe headache and neuralgia in whom, most other causes having been excluded, it was thought an error of refraction must be the cause.

In case 1 the pain was largely confined to the left supra-orbital region, but always with a good deal of discomfort felt in and about the eye itself, which was always aggravated by continued use of the eyes. Examination disclosed a high degree of hypermetropic astigmatism, ample in itself to cause the symptoms complained of. Its careful correction and recorection, however, gave but temporary relief, and it was felt that a further cause must be present; a more thorough exploration of the nasal cavity than was at first made showed a spur springing from the posterior third of the septum and pressing upon and into the turbinate body so deeply that even after cocaine had been used a small probe could not be passed between the structures. The removal of the spur gave entire and permanent relief from all symptoms complained of.

Case 2 had so slight an error of refraction that it did not appear to account for the continuous character of the headache. Exploration of the left nasal cavity disclosed much the same condition as was present in the first case, except that adhesion had taken place between the structures, and, in addition to the use of the eyes aggravating the headache, the slightest exposure to cold would have the same effect. In this case, also, dividing the adhesion, and the removal of the spur gave entire and permanent relief.

REDMOND PAYNE.

CARE IN THE USE OF COCAINE SOLUTIONS.

The indiscriminate use of cocaine solutions in the eye, except for the removal of foreign bodies, the application of nitrate of silver or sulphate of copper, cannot be too strongly condemned. Many general practitioners prescribe it for eye strain, acute ophthalmia,

corneal ulcers, etc., which, if continued for any length of time, its action will decrease the vitality of the corneal tissue, causing a dryness and looseness of the epithelium.

A. E. PHELAN.

OZENA.

In the *Annales des Maladies de l'Oreille, du Larynx, du Nez et du Pharynx*, for July, 1899, Prof. V. Cozzolino of Naples, gives us a complete and useful article on his "Bacteriological and Histological Researches in Ozena." In his examination of 42 cases in people ranging from five to fifty years of age, he was able to isolate the bacillus mucosus in all, the pseudo-diphtheria bacillus, the staphylococcus pyogenes aureus and albus in about 20 per cent of cases, including other unimportant forms in occasional cases.

A number of cultures and also inoculations were tried, and the following general conclusions were arrived at: That the bacillus mucosus is present in all cases of ozena; it is found in the adjacent surfaces of the crust and mucous membrane; that they are in the shape of short rods rounded at the ends and surrounded by a capsule and visible by means of all the methods of staining, but especially so by Ribbert's method. The bacillus mucosus is particularly resistant to antiseptics on account of its capsule.

Intraperitoneal and subcutaneous inoculations of the bacillus mucosus in rabbits, guinea pigs and white mice, proved to be particularly poisonous, death ensuing in a few hours. It is worthy of note, though, that by successive inoculations with small quantities of broth culture, the condition of the animal became refractory to large doses of the culture. Inoculations with serum from these animals mixed with virulent culture of the bacillus mucosus were negative, while animals which were inoculated with the virulent culture alone quickly succumbed. The attempts to inoculate animals by the mucous membrane of the nasal cavity were not successful.

After similar experiments with the pseudo-diphtheria bacillus, the conclusion was that this latter form is only a simple innocent saprophyte, as seen in the nasal fossa of ozenous patients, and only found on the surface of the crusts, which discourages the use of diphtheria-antitoxin. His words are: "It is inconceivable to me how the serum of a bacillus which is not the etiological factor in causation of ozena can be efficacious in the cure; it is a fact well established by my own observation and that of others that the pseudo-diphtheria bacillus is not concerned in the production of ozena, but its presence is only an incident." The apparent usefulness of the diphtheria-antitoxin is due to the excitation of the glandular secretion of the

mucous membrane, with diminution of the mucous stagnation and lessening of the fetidity. The same results can be produced by the internal use of iodide of potash or sodium.

He found that the best results in the treatment of ozena were obtained by curetting the nasal mucous membrane, followed by the use of successive applications of antiseptics.

L. C. DEANE.

TREATMENT OF OZENA, WITH SPECIAL REFERENCE TO CUPRIC ELECTROLYSIS.

In the *Edinburgh Medical Journal*, Vol. 5, McBride reviews the literature on ozena and personally relates the histories of eight patients on whom he employed cupric electrolysis. It consists of attaching a copper needle to the positive pole and inserting it into the inferior turbinated or sometimes into the middle turbinated or middle meatus, while a platinum or steel needle, attached to the negative pole, is passed into the septum. A constant current of from 3 to 10 milliamperes is used, each sitting lasting about ten minutes.

Four of the eight patients were practically cured for a year and over, meaning that for that time the fetor and crusts were absent. Two cases were benefited for a few weeks.

L. C. DEANE.

The Femoral Artery and Vein.

Dr. B. Merrill Ricketts (*Journal of the American Medical Association*, August 12, 1899) concludes a short clinical and statistical article on "The Femoral Artery and Vein. Their Destruction Without Loss of Leg," as follows: (1) Amputation of the leg is not always necessary when the lumen of the femoral artery or vein, or both, is suddenly or slowly occluded by injury or otherwise. (2) It is better to ligate the femoral artery or vein, or both, and give the patient the benefit of the doubt, than to amputate immediately. (3) It is impossible to determine the circulation of the thigh or any given part of the human body without a complete dissection, which can be done only post-mortem. (4) Ligating the femoral artery or vein, or both, in chronic pathologic conditions of the thigh, seems less likely to result in death or gangrene than when the ligature is applied in case of accident in a normal thigh. (5) It cannot be determined what rôle, if any, any one of the six varieties of the femoral artery or vein, or both, have been ligated, as no record of dissection seems to have been made. (6) While end-to-end anastomosis may be accomplished, complete occlusion sooner or later takes place. (7) Suturing and the application of ligatures to arteries and veins which have been lacerated have no advantage over complete immediate occlusion by ligature. (8) Gangrene is possibly due to septic infection and not merely to the occlusion of the femoral artery or vein, or both, unless the vessels for collateral circulation are absent. (9) The preservation of the leg does not seem to depend upon the ligating of the femoral artery or vein, or both, at any particular point.

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SAN FRANCISCO, DECEMBER 15, 1899.

THE SAN FRANCISCO COUNTY MEDICAL SOCIETY AND ITS NEW OFFICERS.

There seems little room for doubt that the past year has been a fairly successful one for our County Society. Goodwill and harmony, two essential factors for success, have been prominent features of all the meetings, and considering this fact and the freedom from factional and personal disturbances, the attendance has been excellent. Many of the papers have been good and the discussions earnest and well considered. The membership, through the efforts of a few, has been considerably increased, and the cash balance added to, to a liberal extent. Much good has therefore come out of the year's work. Of course, the society is not what it should be, either numerically or possibly as a literary institution. The fullest expression of its life and power has not been shown. A spirit of petty rivalry, too little forbearance and consideration is often manifest during the completion of the program. A little charity, gently distilled over the meetings, would lend warmth and a better feeling. More cordiality would aid greatly in dispelling the chilliness that oftentimes hovers over the assemblage. An occasional pleasant word in the society's behalf would awaken hope and interest in its affairs. There is a too ready desire to find fault with and condemn the society for its shortcomings that at present are unavoidable. Such untimely criticisms, as are made in the report of the

executive committee, dampen the ardor of the most enthusiastic, and there is no wonder that the committee complains that "The communications are less numerous than formerly; the demonstrations are increasing in rarity as well as in brevity; the discussions are becoming devoid of the proper animus, and are restricted to and are participated in by very diminutive number of members." To aid this unpleasant condition of affairs: "It is proposed to enlarge the roll and to increase the prerogative of the executive committee, thereby empowering this committee to exact from every member a résumé of the paper, communication or demonstration, which he is desirous of offering at the meeting of the society. The adoption of such a measure would in the opinions of the executive committee be productive of results both in the preparation and in the discussion of subjects." Just such expressions, exemplified in the above, bring about apathy and indifference in the affairs of the society. Against the existence of this idea of censorship, which has been frequently denied, there has been much dissent. We never believed that it had even the foundation expressed in this document. We regret that it was ever brought forward so prominently. The proposal made to increase the membership of the committee is certainly an excellent move, as it would divide the labor and, we hope, do away with any such suggestions as the above. Frequent comparison has been made between the papers and material

offered before the County Society and the Academy of Medicine, the latter being always well supplied and the proceedings thereby rendered of much greater worth. The solution, no doubt can be found in the unrestricted manner of presenting papers and specimens. This report also says that the proceedings of the society, "As they appear, tardively, if at all, in our local journals, are not of such a character as to increase the prestige of the society or to call for encomiums from our neighbors." The first part of this charge is absolutely without foundation as far as the OCCIDENTAL MEDICAL TIMES and the *Pacific Record of Medicine and Surgery* are concerned. No better and no fuller reports have been given the proceedings of this society by any journal, and they have been published with more promptness and regularity than ever before. The latter part is a subject for the consideration of those who have taken part in the discussions during the year. The report also urges the perennial advice of judicious handling of the society's funds in order to some day possess the luxury of a building of their own, and seems to infer that this will aid in building up the society. Of what use is a new building? A place for monthly meetings only! Is it not absurd to hope that in this way the membership can be increased? The few medical societies in the world, who own their own buildings, have made such possessions necessary because of their libraries. We believe that, if a building is desired, we must in the first place make the rooms of the society attractive for the members at times other than those given to the regular sessions. This interest and association can only be obtained by some measure that has a universal application especially where the

members are so segregated by petty differences and dissensions. This universal object is only found in books, and we confidently believe that if the library will be placed at a point where the books will be at hand, where they can be seen and easily reached by the members, if only for a short time after each meeting, that more interest will be evoked and more good feeling engendered by the personal contact thus brought about, and, therefore, urge that a portion of the money lying comparatively idle shall be spent for books and subscriptions, since herein lies the hope of union and strength for the society's welfare. Another consideration which would possibly aid in encouraging interest would be the limitation of original papers to not more than 20 minutes in the reading, followed by discussions limited as to time and subject. These papers should be practical, brief and to the point. Demonstrations of specimens and instruments should be encouraged. Too much time is consumed in the narration of the history of cases and too little given to the practical and everyday points in the treatment. The discussions are too general, too full of narrative. The course for future meetings, as mapped out by the incoming president, seems to be worthy of consideration and a trial.

The following officers have been unanimously elected for the ensuing year:

President, E. E. Kelly.

First Vice-President, S. J. Hunkin.

Second Vice-President, Harold Brunn.

Recording Secretary, G. H. Evans.

Assistant Secretary, W. F. Barbat.

Corresponding Secretary, L. M. F. Wanzer.

Treasurer, Philip King Brown.

Librarian, Philip Mills Jones.

THE CLOSE OF VOLUME XIII.

With this issue, the 13th volume of the OCCIDENTAL MEDICAL TIMES is closed. The two journals, of which the TIMES is now the sole representative, have undergone several changes during the last few years, but none have been so advantageous or have added so immensely to the welfare and standing of the journal as the consolidation which was effected in July. Nothing but praise and goodwill have come from both subscriber and advertiser. Notwithstanding the success, which has attended our efforts to give the profession a worthy medium, we are by no means satisfied with its present condition, but hope during the coming year to improve it to a degree commensurate with the hearty reception extended by its patrons. To this end the first change proposed will be to issue the journal on the first instead of the fifteenth of each month. Again, the departments, a most valuable feature of medical journalism, which for many reasons have been omitted, will now be run regularly even at an increased cost. We have been promised monthly reports from our hospitals, giving a brief history of the most important cases, their treatment and the results.

In this issue will be found an index to the Pacific Record of Medicine and Surgery, from December, 1897, when we assumed control, to June 30, 1899, when that journal was consolidated with the OCCIDENTAL MEDICAL TIMES; also one from this journal from the 15th of July to December 31, 1899.

NOTES.

THIRTEENTH INTERNATIONAL MEDICAL CONGRESS.

The Thirteenth International Congress of Medicine will open at Paris on August

2, 1900, and close on August 9th. Membership will be granted: 1. To all doctors of medicine who apply for membership. 2. To the representatives of science who shall be presented by the French Executive Committee, or by the Foreign National Committees. Members will receive their cards on forwarding the sum of 25 francs to be paid to the treasurer-general of the Congress. This card will be required for admittance, and to secure for the members the advantages reserved for them. Members will be entitled to receive a digest of the proceedings of the Congress and the printed report of the section to which the member belongs.

All communications should be addressed to Dr Henry Barton Jacobs, 3 West Franklin St., Baltimore, Md.

McNUTT HOSPITAL.

A very important change has taken place recently in the management of one of our local hospitals. The McNutt Hospital, a private sanatorium with a capacity for the care of fifty patients and provided with a full corps of trained, medical and surgical nurses, is now under the full and complete control of Dr. McNutt. The change brings new life and energy to the institution. Any reputable physician can treat his patients in this hospital, and every care and convenience will be offered to both physician and patient.

CORRESPONDENCE.

SOME OBSERVATIONS IN THE EYE CLINICS OF LONDON, BERLIN AND PARIS.

The months of August and September, the time when American physicians are best able to take a vacation, are the months when many of the best men in the European clinics are, unfortunately, for us, also absent on their vacations. However, there are generally skilled assistants in charge of the clinics,

and any observing physician can find much of interest at all times.

The principal place of interest to oculists in London is the Royal Ophthalmic Hospital. In July preparations were being made to move the hospital to a new and more commodious building, and therefore they were not doing as many operations as usual. This is a particularly good place to see a large amount of work done in a rather conservative manner. The surgeons at this hospital are much less likely to vaunt new and untried treatments than the French. For that reason it is a good place for the beginner—for one who has had more experience and is better able to estimate the value of the numerous fads he sees in the Paris clinics, the varied experience is beneficial. Moorfields is a particularly good place for one to learn retinoscopy, the use of the ophthalmoscope, etc., on account of the abundance of material and also because retinoscopy is there better conducted than in the continental clinics.

Nearly all of the cataract operations in this institution are done with an iridectomy. There have been few advocates of the simple operation in this hospital, and some who had previously practiced it have returned to the combined method. I was particularly interested in the extraction of a piece of steel from the vitreous by the use of a hand magnet. The steel, which was of considerable size, was drawn through the lens and out of the corneal wound of entrance. The hospital will have a Haab magnet when located in the new building. There is no doubt that it has decided advantages over the hand magnets, and that useful eyes will occasionally be saved by it that would otherwise be sacrificed. The English characteristics are noticeable in all fields of human activity, and one of the most marked is their conservatism. One finds many of the diseases of the eye treated at Moorfields to-day as they were twenty-two years ago when I was a student at that institution. Even the French, who are very fond of trying new things, often return to the same old treatments that the English adhere to with pertinacity. In retraction of the lachrymal puncta Lang cauterizes the conjunctival surface of the lower lid with the galvano-cautery to restore the puncta to its normal position instead of slitting the puncta as is usually practiced. Mule's operation is frequently practised instead of enucleation.

The rules of antiseptic surgery are observed here as well as in most hospitals and clinics that one sees. The instruments are boiled and the eye is prepared by careful cleansing previous to operation. Ophthalmic surgeons perhaps pay as little attention to the rules of asepsis as any surgical specialist. Indeed, I saw one Paris oculist of international reputation use instruments that were not even washed from one operation to another—simply wiped with cotton or a napkin, and the eyes were not prepared by cleansing. The fact that this can be done without very marked bad results, shows, I think, that the

eye is not a favorable culture field for pathogenic germs.

Knapps' roller forceps is generally used for operating upon granular lids in Moorfields. In Abadies clinic in Paris cases of granular lids are treated by scarification and brushing with bichloride solution, one to one thousand. The patient is always chloroformed and the lids are averted by aid of a pair of forceps by which the whole conjunctival surface can be exposed. The scarifications are made through the granular tissue and well brushed with the bichloride solution with a stiff brush. This treatment has been used in this clinic for many years with good results. One reason that the results have been so uniformly good here is, I think, because of the thoroughness of the operation. In a number of cases I saw the eyes almost restored to a healthy condition after two weeks treatment. In a number of other clinics a solution of bichloride, one to one thousand, is used daily or twice a week for trachoma, by strongly rubbing the solution into the diseased conjunctiva with a pledget of absorbent cotton.

Professor Schweiger, of Berlin, does not operate much of late years, but his assistants are skillful and have an abundance of material. Removal of the lachrymal sac for chronic dachro-cystitis is done there very much with favorable results. The sac is entirely removed and the skin wound united by sutures to heal by immediate union. Cases which cannot come to the clinic to have proper treatment and those that have resisted a reasonable treatment by probing and syringing are operated upon. In Berlin cataracts are generally operated upon without an iridectomy, but a few operators have returned to the combined method.

In Professor Hirschberg's clinic I was particularly interested in seeing a piece of steel extracted from just behind the lens. It was first drawn around the lens and through the iris into the anterior chamber by a large electro-magnet connected with the street current and then taken from there by the small magnet through a peripheral corneal incision. Most of the cases of granular lids that I saw in Berlin were given the old treatment of sulphate of copper, either in crystals or in solution, or nitrate of silver solutions.

Bichloride solutions are used in the clinics very generally for purulent conjunctivitis and also in serpiginous ulcers of the cornea. The galvano-cautery has come into almost universal use in the latter disease when the infection seems to be extending. If hypopyon exists the accumulation is promptly evacuated. Dachro-cystitis is found to be the source of infection in a large percentage of these cases, and the sac receives prompt treatment by syringing with appropriate solutions. In Paris, in addition to the above, some of the men use subconjunctival injections. Seven years ago phlyctenular ulcers of the cornea were treated at Dr. De Wecker's clinic by instillations of methelyn blue solution. To-day these cases and many others are treated

by subconjunctival injections of bichloride solution. I remember that Dr. De Wecker criticised Dr. Darier rather severely at that time for his general use of this method of medication in a discussion before the French Ophthalmological Society, but a visit to his clinic now shows that he has become a convert and is using the method much more generally than Dr. Darier himself. Dr. Darier at present uses the cyanide of mercury instead of the bichloride for subconjunctival injections.

Unless one speaks French fluently and become an assistant in some clinic, Paris is not a particularly good place to spend much time. Vienna still possesses many advantages over other European cities for the study of specialties. There is more attention given there to private instruction, and many of the assistants speak passable English, which is a great advantage to most Americans, who, as a rule, speak very indifferent German. Americans who do not take the trouble to learn to speak German fairly well will generally do better to spend most of their time in London. Living in Berlin is cheaper than in other large European cities and for certain kinds of work it has advantages over Vienna or London.

One is usually received with civility and often with cordiality in most European clinics. For a short attendance no fee is expected. If one expects to have much time devoted to him he would naturally want to give compensation for the attention. In one Berlin clinic a friend of mine asked the Professor what he should do to have the privilege of attending his clinic for four weeks and was told that he should pay forty marks which he promptly handed over.

Three days later the Professor disappeared on his vacation and left a very young assistant who was not of sufficient experience to make it worth while to spend the time with him. Such instances of grasping disposition are happily rare, and a foreigner, whether he be an American or a Russian, generally receives as good treatment as his qualification and his conduct deserve.

Paris, September 5, 1899.

WM. ELLERY BRIGGS.

SURGICAL CLINICS OF GERMANY.

No doubt you have long since come to the conclusion that my promise to write you an occasional report of my experiences, like all promises, was made to be forgotten. Such, however, is not the case. The difficulty has been to decide what to write. To enumerate the operations seen, would be a compilation of worthless statistics to any one but myself; to describe certain interesting operations would be anticipating their publication and would hardly come within the scope of a letter of this kind; I shall, therefore, limit myself to a short sketch of my impressions of the men and places visited, and in conclusion offer a few remarks on a subject of great general interest, namely: The present status

of asepsis and antisepsis with especial reference to the sterilization of the hands.

I shall preface my remarks with an enumeration of the places visited during my tour of the German schools, Berlin, Breslau, Leipzig, Bonn, Heidelberg, Freiburg, Vienna, and as a fitting climax the Meeting of German Naturalists and Physicians at Munich. I may state here that I was in Bern, but Kocker had gone on his vacation; however, I shall go back there shortly and expect to remain sometime, for of all German surgeons his is the name that to-day is mentioned with the greatest respect.

Berlin. Ah! Berlin is an immense city, not alone in size and population, but in life, commercial enterprise, amusement, everything that goes to make a great modern city. But that does not belong here. Some day when there is nobody listening I will tell you about Berlin as she is. I had not been there twenty-four hours before I strolled into von Bergmann's clinic, the Mecca of all students of surgery coming to Germany. I had been there before, years ago, and knew what to expect, still it was a shock to me. A few days later I was admitted into the sacred precincts of the arena and added my head to those that obstructed the view of those above, but there were still heads ahead of me and to stand two hours in one position without being able to stir soon dampened my ardor. I quit. V. Bergmann is an extremely rapid and dexterous operator, everything goes with a rush; he never finishes an operation, but leaves that to be done by his assistants in the rear of the room while the next patient is brought on. His assistants work in relays and even so they have considerable difficulty in keeping up with him. In accordance with this, his operations are of the display, or, as we would say, "grand stand" order. Long and tedious operations such as pyloric resections, etc., are rarely done; they are left to the assistants; in fact, they have great opportunities as the old gentleman seems willing to rest on his laurels, and has so much outside work that the bulk is left to them. Accordingly if you want to see the material at this clinic you must make the acquaintance of the assistants as I was fortunate enough to do, and go there in the morning when you will often find two or three of them operating at the same time with a screen between the tables. Beside the amphitheatre there is a large modern operating room for abdominal work. This is a sort of "Holy of Holies" where only the initiated may enter. I have been told that for young men coming to Europe and just entering the domain of surgery there is no greater opportunity for studying surgical diagnosis and minor surgery than by securing the position of "voluntair" in V. Bergmann's polyclinic. This for the benefit of our recent graduates, who may contemplate coming abroad and another pointer, *en passant*, beware of the private courses. The other university clinic is at the Charite, that venerable collection of buildings, one of the oldest hos-

pitals in Europe, which is now being gradually reconstructed to meet modern requirements. Here Koenig presides, who was called hither a few years ago from Gottingen to replace the genial old Bardeleben. Koenig is an excellent teacher, a good diagnostician and a slow but careful operator. In speaking to him of his material he complained that it was too greatly scattered in Berlin, that he had decidedly more in Gottingen than here. Koenig is a teacher above everything else. Beside the university clinics, there are the three municipal hospitals, which deserve attention, situated respectively in the north-eastern, northwestern and southern parts of the city, miles apart. At the Friedrichshain Hospital, Hahn is the surgeon, a very jolly old gentleman and a bold operator. He believes in silk for sutures and ligatures to the exclusion of all other materials, and is a convert to the cotton gloves and masks of Mikulicz which, however, he very frequently forgets to wear. His material is very varied, and his clinic interesting and instructive.

Sonnenburg is the surgeon at Moabit. He has recently been made a "geheimrath." What good that does him I am unable to state, but it seems to be one of the requisites to perfect happiness in this country. He reminds me for all the world of our late lamented friend Dr. John F. Morse, the same size and build, the same mustache (except grayer) and the same short, sharp determined manner. Sonnenburg is the German authority on appendicitis, and his clinic is full of cases. I have seen as many as four or five severe cases operated on in the course of a single morning and his results are marvelous. He does not believe that because a man has a bellyache, fever and constipation, his appendix must be immediately removed. Concerning him, there is a rumor among the Americans, who have not seen him, that in this operation he makes a thirteen-inch incision. It is not quite as bad as that. In recurrent cases where the operation is done in the quiescent stage, decidedly not, but where perforation and supuration have occurred the opening is free and the cavity is *tamponed*, not drained, huge quantities of gauze are packed in. Whether the secret of success lies in this thorough packing I am not sure. It is true that the scars are large and I am told hernia rather frequent, but on the other hand, mortality is very low; of all the cases I saw not one died and many of them were in a condition that I expected them to die as they were being carried out. He begins his incision about a finger's breadth in front of the anterior superior spine of the ilium and cuts down to and making a very acute angle with Poupart's ligament. The muscles are rapidly divided and the peritoneum bared, then with his fingers he works down extraperitoneally until he feels the abscess, infiltration or swollen appendix when he enters the peritoneal cavity at that point. It must not be thought that this clinic is devoted entirely to appendicitis, though the cases are about as numerous as

cancer of the breast at Von Bergmann's. Among the smaller points of interest I might mention that the catgut and much of the gauze used here are impregnated with silver salts.

The other municipal hospital and the newest is the Urban. Koerte is the surgeon. Unfortunately I failed to visit this place, but expect to do so shortly on my return to Berlin. The same applies to Israel at the Jewish Hospital. Both men are surgeons of considerable repute.

In our résumé of the Berlin surgical celebrities we have followed the strict German method of beginning with the highest titular dignitary, the Wirkliche Geheime Rath Mit dem Bradikat Excellenz. We come now to the plain practicing physician and we find among them a man, connected with no school or official clinic, who has met such violent opposition, due, it is true, to a great extent to his impulsive nature, that would have crushed most men, with an originality and a world-wide reputation that few geheimrathe can ever hope to attain. I refer to Schleich. He has a private clinic way down at the lower end of the Friedrichstrasse, which is well worth a couple of visits. His method for local anesthesia you are no doubt acquainted with. Regarding his general anesthetic, you will probably not know that he has recently modified it. He has found that the petrolic ether is rather unstable and has substituted for it ethyl chloride. Antiseptics have been absolutely abandoned in connection with operations, he has a special soap containing marble dust which he uses to wash himself and the patient. I shall refer to this more in detail later. A number of other interesting questions have been studied by him, for he is an indefatigable worker, and been recently published in a small work entitled "New Methods of Treating Wounds." It has not been translated, he asked me if I would not like to undertake it, but, at present that is out of the question. Possibly, after my return unless some one tries it in the meantime, I may tackle it.

Now for a few words in general regarding matters medical in Berlin and they apply to a greater or less extent to all the large cities in Germany. The life of the ordinary practitioner must be far from a rosy one. I am informed on what I consider good authority that two-thirds of the Berlin physicians have an income of less than two thousand marks (\$500) a year. The question in my mind has been: "How do they manage to make that much?" When you consider the innumerable clinics and furthermore the fact that all working people are required by law to belong to a Kraukenkasse, operating like our lodge system, I don't see how there can be much left. The system for attending to accident cases, corresponding to our Receiving Hospital system, bless the mark, is in the hands of three organizations, among whom there appears to be considerable rivalry and jealousy. A large number of stations

are distributed throughout the city, supported to a great extent if not entirely by private subscription. These positions are the bone of contention among the younger surgeons, who after years of hard study and patient slaving as assistants are striving for a name and the incidental shekels.

Breslau. Candidly, Doctor, did you ever hear of Breslau? I must confess I thought I knew Germany pretty well and had always considered Breslau a God-forsaken little berg near the Russian border. Imagine my surprise to find a great commercial and industrial center of over 400,000 inhabitants, a population greater than San Francisco—that is, before the soldiers came. The clinics are new and handsome, surrounded by well kept grounds and constitute a quarter by themselves a short distance out of town. The surgical clinic is everything that a modern clinic should be, the lecture room is large and well appointed and only minor operations are performed here in the presence of the students, who, divided into small sections, alternate in their visits. I consider this a very wise provision, since then the men really see something and it avoids crowding. The department for operations is in a separate wing. As you enter, there is a rack for hats and coats, as you are required to wear a linen gown and rubbers, the latter for the reason that the floor is repeatedly flushed. There are two waiting rooms for male and female patients, respectively, a dressing room for the assistants, a room for anesthetization and one for sterilization of instruments and dressings, both leading into the operating room from opposite corners. The operating room itself is large, well lighted, well ventilated, heated with steam and tiled throughout. There are two metal tables between which are the stands for instruments and dressings, then there are a few movable iron rods connected by chains behind which visitors are expected to take their places; also assistants not engaged.

Mikulicz—I should say—"Von Mikulicz-Radecki" as he has just entered the Nobility," is a very pleasant gentleman and very courteous to visitors. (I spent a very jolly Fourth of July at his house, even had fireworks.) Physically he is a very small man, but extremely energetic. He is suffering from tic convulsif of the face so that when talking to you he seems to be constantly making grimaces which entirely cease when at work. He is a tireless and earnest investigator, an excellent teacher and diagnostician and a bold, rapid operator. His discovery of the fact that no matter how thoroughly the skin is scrubbed and subjected to various chemicals, it cannot be sterilized owing to the hair-follicles and glands, whose depths swarm with bacteria, which while continually working out to the surface, is a factor of fundamental importance in this weighty question and has led in his case to the use of the cotton glove. There are many other interesting features in this clinic. To prevent hair, etc., falling into the wound, all wear sterilized

linen caps, and to make assurance doubly sure the nose and mouth are covered by an apparatus like an Esmarch mask, which fastens behind the ears like spectacles, and where there is a beard a piece of linen is fastened to the mask, covers the beard, and is tied at the back of the neck. The dressings and sponges are not handled except by the operator; they are taken from the receptacle in which they were sterilized and handed to the operator by means of long sterile forceps; the same rule applies to instruments, when dressings are changed in the wards. Every ward has its separate dressing room. I know that these different features have been greatly ridiculed and criticized, but results tell, and at this clinic they are wonderful. Aside from the usual suture materials he is very fond of aluminum-bronze wire. I do not remember having seen it used before. The clinical material is huge and varied in amount, not alone do they draw from a large district around the city, but a considerable contingent comes across the border from Russia. Operations begin during the semester at 8:30 or 9 a. m. and continue until 4 or 5 p. m., interrupted for one hour for the lecture, mainly a demonstration of cases and minor operations. This goes on day after day, sometimes both tables are filled simultaneously, and after the clinical work is done, the professor goes to his private clinic, a large institution across the street. Sometimes you are invited, naturally you must go, though your American stomach will mutter in disgust. If the operations are over fairly early a good proposition is, after satisfying the inner man, to return about 5 or 5:30 and visit the wards to see the dressings, thus enabling you to follow the cases and pick up many little practical hints. There is no clinic where you are so well treated and allowed to make yourself so much at home as here. I will admit this may be due to the fact that visitors are not so numerous, and probably the privileges have not as yet been abused. I hope they never will be. A very interesting line of thought is opened by a procedure, I might say, almost peculiar to this place. A sterilized chloroform mask is used for each case. In conclusion, if you ever come to Europe do not fail to visit Breslau.

Leipzig. I was in a curious dilemma as I approached this place. The name of Tillmanns was very familiar on account of his excellent text-book on surgery, and naturally concluded that he was professor of surgery. Several German colleagues to whom I mentioned my intended visit to Leipzig spoke of Tredelenberg, who with most Americans on account of the peculiar position, connected with his name, used so frequently in gynecology and abdominal work, I thought, was concerned with that specialty alone. I was therefore naturally very cautious when I entered the surgical clinic. I was very cordially received by the professor, who showed me about the place in person taking particular pride in his operating room, now in course of

construction. The word room is a misnomer, as it is a large building containing a large lecture room with a small operating room, a room for photography, a room for using the Roentgen rays, etc., in fact when completed will be probably the most complete of its kind. After 2 or 3 hours, I accidentally learned from Birsch-Hirschfeld, the famous pathologist, to whom I had been introduced, that I was in company of Trendelenberg. Now the question came, who and where is Tillmanns? I applied for information to the hotel porter, for in a good hotel this gentleman knows everything, and I was informed to my great surprise that he was the surgeon at the Children's Hospital.

Tillmanns received me very kindly, in fact, I met him subsequently in Munich where we became quite good friends. The hospital is quite new and very modern in its appointments, unfortunately, however, there was little doing just then.

Bonn. The change was startling, next to Mikulicz, of all the men I have seen none have the amount of work of Schede. Besides the university clinic he has the Johanness Spital, an institution under the charge of a sisterhood and in the immediate neighborhood of the clinic. Schede is another of those men, who have learned to do without meals during the day. I have gone to the clinic about 8 a. m. and not left the Johanness Spital until after 6 p. m. It may be a good thing when you get used to it, but my experience has been that it is a hard lesson. Schede is not a brilliant operator but a careful investigator and tireless worker. He is very fond of silver wire and claims that with buried sutures of this material ventral hernias are well nigh impossible. He has a novel method of anesthesia. In the operating room there are a number of stopcocks, connected by a pipe with a reservoir and distilling apparatus in the adjoining room, so that when the stopcock is open a definite mixture of chloroform, ether and air escapes. A hose is attached to the stopcock at the end of which is a nozzle with a screw arrangement so that the amount of escaping mixture can be absolutely controlled. The nozzle is fitted into a wire mask, this, however, can be readily removed and the nozzle placed in the mouth or simply held over the face, an advantage in operation in this region. Schede has also invented an apparatus, which is very useful in orthopedic work. It amounts to a horizontal suspension instead of vertical, more comfortable for the patient and decidedly more convenient for the surgeon. It is also used in replacing congenitally dislocated hips, for you must know that the bloody operation has been entirely abandoned as unsatisfactory. As Lorenz said to me "It represents simply a preliminary stage in our study of the treatment of this condition."

Very truly yours,

H. B. A. KUGELER, M. D.

Berlin, Central Hotel.

SOCIETY PROCEEDINGS.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Regular Meeting September 19, 1899.

The President, H. W. Shader, M. D., in the chair.

Dr. W. H. Wentworth read a paper entitled "Medical Practice in Guatemala" (published on page 559).

Dr. A. M. Henderson: "The State law for the qualification of doctors in California is defective. But the State Legislature will apparently do nothing. Even medical members give no heed to appeals for such legislation. There is more stringent legislation in many of the eastern States, and they have raised the quality of the profession by these means. Schools rival each other to have the fewest number rejected. These States accept each other's licentiates, but we have no such defense. Montana has rejected one-third of all applicants in the last ten years."

Dr. H. S. Nichols: "I agree that there should be more stringent legislation on this subject in California."

Dr. H. H. Look: "There should be better legislation, but this costs money and is difficult to obtain."

Dr. L. A. Harcourt: "General national legislation is what is demanded. All other countries are much stricter than America in this respect."

Dr. W. A. Briggs: "The profession should be more united on the question of legislation. Without this we can make no progress. We are not aggressive enough. California is more and more the dumping ground of poorly qualified men. We must follow the lead of the more advanced States in the East. Public sentiment is against such legislation as that proposed, and this must first be educated."

Dr. H. D. A. Power: "National rather than State law is what is required. Merely to keep out competitors, not to raise their own standard, seems the desire of some States. Interstate Medical Society action is the next best thing to a general law. A man suitable to one State should be acceptable in any State. A central national board would be a good thing. International retaliatory prohibition is not, however, proper. Men from satisfactory colleges in America are allowed to practice in England."

Dr. G. L. Simmons: "Legislation fails because the people do not demand it. They regard it as in the interests of physicians. The present law elevates the eclectic, etc., to the ground of the regular. The homeopaths of the San Bernardino Asylum have run the asylum well along regular lines, and have won elevation for themselves by means of it, which has happened solely through this law."

MEDICO CHIRURGICAL SOCIETY.**ANTERIOR LUXATION OF THE INNER ENDS OF BOTH CLAVICLES.**

Through the secretary, Dr. C. F. Griffin, Dr. T. L. Meinhard made the following report:

Patient, aged 19, presented himself about three and a half years ago, an account of prominences at the sternal extremities of the clavicles. Family history is very good, both parents, two brothers and three sisters are living in good health. The patient is fairly well developed, has grown considerably within last two years and is an enthusiastic athlete. He called first out of curiosity to know whether the prominences were normal or not? On first examination more than three years ago the sternal ends of both clavicles were slightly prominent, the right more so than the left. There was no complaint of pain or any discomfort at this or at any subsequent time. During his school vacation and after a period of hard work one year from first examination, he called again and said that his trouble was increasing. Examination showed greater prominence and apparent increase on the right side. Left was unchanged. No interference with motion. About six weeks ago the conditions seemed to have changed considerably; the right clavicle at the sternal end was found dislocated upward and inward, the left projected slightly forward. Reduction of the luxation can be accomplished, but proper approximation and retention of both clavicles will be found difficult, requiring specially designed apparatus.

Dr. L. C. Lane: "I think the diagnosis has been well and properly made. The method of treatment is a much more difficult problem to solve. Nothing short of an operation, in which an opening could be made, and the sternal end of the clavicle and the upper end of the sternum united by suture would be sufficient. This would probably cure him, but it is a question whether or not the result would justify it. The sterno-clavicular joint is one in which it is necessary that there should be some motion. The movement of the arm requires that the inner end of the clavicle should not be firmly fixed as if it were a continuation of the sternum, but that there should be a joint there. A similar condition of things has been frequently seen from an accident at the acromial end of the clavicle. I have seen a few cases of this kind. The proposition to treat them by metallic suture was first made by Dr. Cooper in 1859. Some think that this procedure would not materially improve the patient's condition. I did it in two cases, however, and if it did not benefit the patient's locomotive apparatus there was one thing very certain: it made him much more satisfied with himself, and he was delighted that the bone remained in place. There is very little movement at that part—much less than at the inner part where you have a certain degree of rotation. One of the great

four interarticular cartilages is found here and at the sternal end. I think if the young man were my patient, and if he were satisfied with his condition and has good use of his arm, I would not perform the operation of clavicular suture."

Dr. R. L. Rigdon: "I think if there were complete luxation and the ligaments were torn that there would be more forward position of the shoulder, and naturally the shoulders could be bent forward together. One of the offices of the clavicle is to retain the shoulder in position, and if this were a complete luxation, I should think that the shoulders would be lower. I conclude that the bone is not completely luxated, but still is held quite firmly, probably by the ligaments; and that on that account he has good motion."

Dr. C. F. Griffin: "I would like to ask, as a matter of information, what explanation can be offered for the undeniable enlargement of the inner half of this clavicle? It seems to me that it is nearly twice its natural size."

Dr. C. N. Ellinwood: "It occurs to me that it is due to constant use, constant motion. It is an enlargement of the bone purely. He has perfect development of the extremity of the bone. How does that strike you, Dr. Ophüls?"

Dr. Ophüls: "It would seem to me that the enlargement is not a real one at all. The bone has been brought forward on account of the misplacement. It is only apparently more prominent."

EXHIBITION OF SPECIMENS.

Dr. Wm. Ophüls showed a number of interesting pathological specimens, among them being a large intestine with extensive amoebic dysentery ulcers. The process had extended to the liver, and then had passed on through the diaphragm to the lung. There was no communication between these foci in the lung and the bronchial tubes. Here is a bladder with a very large tumor mass. In the lower part of the bladder there are found a large number of deep ulcerations, and a very large abscess has formed and destroyed the entire prostate. There is hardly anything left of the kidneys. A microscopical examination showed that there were many tubercles present as well as carcinomatous ulcerations. So that the specimen shows a condition not commonly found, tuberculosis and carcinoma in the same individual or even in the same tissue. It was at one time believed that this combination of diseases never occurred, but quite a large number of cases of that kind have now been reported. I think that in 1894 it was possible to collect about 180 cases of that kind.

"This ulcerated uterus has considerable clinical, and, particularly, some medico-legal interest. Ordinary inspection seems to indicate a laceration of the cervix, produced by the introduction of some sharp instrument. Here is quite a deep ulcer, with nothing in particular at the bottom of it—no pus that would show tuberculosis. The tissue seems

to be lacerated. A localized peritonitis has been set up. There is no sign of tumor formation, yet nevertheless, microscopic examination shows the process to be simply a carcinomatous ulceration.

"This apoplectic brain specimen has no interest from a pathological standpoint. I should like to show it simply as a specimen of preservation of natural colors. In this case the blood color shows very prettily. It is possible to show the red coloration, where the clot has been. Not very long ago there was published a very extensive article, in which the author described and gave all the data necessary to make specimens of this kind. Kaiserling's Fluid—Formalin, 200 c. cm.; water, 1,000 c. cm.; nitrate of potash, 15 gram; acetate of potash, 30 gram. It is better to inject part of this fluid into the blood vessels before the specimens are opened in order to allow the fluid to enter the tissues more thoroughly. After this they are immersed in 95 per cent alcohol. The specimen must be washed carefully until the red color of the blood has reappeared. Soon after this washing the blood assumes a dark brown color, then you put it again in the alcohol. The brown becomes redder and redder and you have to wash it again until the blood vessel assumes its natural color. Considerable judgment is necessary in this part of the process. The time necessary is usually from three to twelve hours; then they are put into the fluid in which they are kept and for that we use: Water, 100; acetate potash, 10 -5; glycerine, 20 -5. This specimen has not been hardened that way exactly. I think that the acetate of potash makes the specimen too transparent. It is of great importance that the specimens be hardened thoroughly before they are put in alcohol; because if they are left in very long then the color disappears slowly again, and the blood becomes more brown in color. When the specimens are put in the first solution, it is necessary to put them in exactly the right form for preserving, because they harden so much that it becomes difficult to shape them differently after the fluid has acted upon them. This method is not particularly new, and there are several others like it, all resembling one another more or less, but this one seems to me the easiest as well as the one which gives the most satisfaction."

SAN FRANCISCO SOCIETY OF EYE, EAR, NOSE AND THROAT SURGEONS.

INTRACRANIAL TUMOR.

The President, Dr. W. A. Martin, in the chair. On behalf of Dr. Leo Newmark and himself. Dr. Martin presented a young man, aged about 35, with the following history: Patient came to the Polyclinic August 11, 1899, stating that he had been under treatment for several weeks for headache, and was referred to Dr. Martin on account of eye

trouble, which had developed in the past week. On examination the right eye was fixed in the primary position, the only motion being obliquely upward and outward and downward and inward. There was no ptosis. Vision was normal excepting a small refraction error. Pupil did not differ from left side and reacted both to light and convergence. Fundus was normal. Naturally he was troubled with double images, but his principal complaint was an excruciating pain in the left temple which extended to the vertex and was continuous day and night. He also complained of a numb feeling over the right eye. Suspecting that an intra-cranial tumor located near the sphenoidal fissure was the source of the trouble, he referred the patient to Dr. Newmark for further investigation.

Dr. Newmark reported that beside the nerves supplying the extra-ocular muscles, viz: the third, sixth and fourth, that the first and second branches and possibly the third branch of the trigeminus was involved to a greater or less extent. There was no history of a specific or other affection, and Dr. Newmark was of the opinion that there is a tumor, probably a fibroid, located to the right of the sella turcica. Careful examination was made as to possible trouble in the sphenoidal sinus, or intra-nasal trouble, but neither was found. Patient was placed on specific treatment; inunctions and the iodid, running the latter up to 70 gr. t. i. d. This treatment was continued about ten weeks as the eye movement was found to improve. The pain, however, was continuous and had to be controlled by morphine. On September 18th it was noticed that the optic disc looked woolly or edematous, and Dr. Martin predicted that the optic nerve was becoming involved although vision had not yet suffered. Three days later when he came to the clinic, he was totally blind in the right eye. Dr. Newmark thought that under the conditions, an operation was justifiable, and one was performed by Dr. Bazet of the Polyclinic staff, at the Waldeck Sanitarium. An opening was made in the skull in the temporal region, shaped like an inverted U with the open part hinging on the zygoma. It was impossible to get beyond the foramen ovale, but nothing of the nature of a neoplasm was discovered in that region. The wound was closed and healed by first intention. The patient was relieved entirely of the pain for a week, but after the drainage tubes were removed and the wound closed, it returned with all the former intensity. At the present time the movements of the eye are decidedly improved from the original condition, whether as the result of the operation, or of the internal treatment, or, as Dr. Newmark suggests, by the shifting of the pressure, it is difficult to determine. The vision, however, has not returned, and the right is showing a gradually increasing atrophy.

On November 13, when he came to the clinic, he complained of a haziness in the left eye. Dr. Martin found a perineuritis developing; the veins were enlarged and the margin

of the disc hyperemic and indistinct. The vision was not tested as patient was in a highly nervous condition over the possibility of losing his sight altogether. Unquestionably the left optic nerve is being impinged upon at the present time. The field of vision has showed no peculiarity. There is no ear trouble.

Dr. Leo Newmark believed a plausible assumption that there is a tumor in the right middle fossa, and that its presence would account for the implication of the oculomotor, abducens, trigeminus and optic nerves. In lepto-meningitis there is not such severe pain. Whether the growth is in the bone at the base or in the brain at the base cannot now be told; that the nerves are affected near the middle line, is certain.

CARCINOMA OF TONSIL.

Dr. Henry L. Wagner presented a case of carcinoma of the left tonsil in a man about sixty years old. He also showed microscopic sections of the growth, and stated that the case is a rare one, since sarcoma is the rule in malignant tonsillar disease.

Dr. Cohn said that it would be important to examine Dr. Wagner's slides under a high power since carcinoma is very rare in the tonsil.

Dr. Barkan asked Dr. Wagner how carcinoma can be distinguished clinically from sarcoma.

Dr. Wagner replied that sarcoma progresses rapidly, and carcinoma (round celled) slowly. In undoubtedly malignant growths of the tongue, pharynx and tonsil, mercury temporarily produced an apparently curative affect.

Dr. Kaspar Pischel presented a young girl, who had had at intervals since she was six years old, attacks of otorrhea. Fifteen months ago the left ear began to discharge again, and there were attacks of dizziness. The membrana is intact; whisper heard six feet. On the upper wall of the external canal is an opening 1 centimetre from the membrana. On inflation air and muco-pus escape. On account of the amount of hearing he was inclined, in case it became necessary to operate, to do so by way of the antrum.

Dr. Barkan thought it difficult to tell in this case whether or not the attic and ossicles are affected. Dilute muriatic acid might be useful.

The President had seen several similar cases, and believed the only safe procedure in Dr. Pischel's case would be a modified Stacke operation.

NEW FORM OF TROPOMETER.

Dr. F. B. Eaton presented and demonstrated, by request, his two new forms of tropometer, the double arc, and the reflecting form (*Ophthalmic Record*, September, 1898, and August, 1899). Careful and patient experiments with different forms of perimeter had

shown him that that instrument cannot be either conveniently used or relied upon for the purpose of determining the monocular field of fixation, which is coming into prominence as a regular clinical procedure. He had been able to clear up puzzling cases of paralysis of the ocular muscles, where secondary contractions had taken place rendering the diagnosis by false images impossible. In nearly all cases where operations on the muscles are contemplated, a correct knowledge of the actual amplitude of fixation in different directions is almost indispensable.

The President stated that recently in a case of old paralysis of the right inferior rectus, where the indications of the false images were contradictory, the use of the double arc instrument of Dr. Eaton had enabled him to quickly determine that the internus of the other eye was involved and to prescribe prisms which gave relief.

Dr. Barkan presented some of the improved artificial eyes of Prof. Snellen. He doubted whether they would supersede the present form of shell prothesis.

Dr. Pischel showed some stereoscopic photographs of the temporal bone, by which the anatomical relations in different operations and conditions were rendered clear and life-like.

CALIFORNIA ACADEMY OF MEDICINE.

RESECTION OF ELBOW.

Dr. Harry M. Sherman presented a patient on whom he had performed resection at the elbow joint for tuberculous disease. Dr. Sherman said: "The particularly interesting feature of this case is an incident that occurred during the operation and which shows the resistant character of nerve tissue. The ulnar nerve was exposed for about 3 to 4 cms. of its length. It is my custom to swab out the wound with pure carbolic acid. I did so in this case, not thinking for a moment of the exposed nerve. It occurred to me that the nerve might suffer, so I then carefully wiped off the carbolic acid, cleansed the wound and packed it. In due course healing took place, but at no time was there any trouble arising from the application of the carbolic acid. An abscess formed in the cicatrix but this I scraped out and cauterised. The wound then healed well, and as you see the young man has a fairly useful joint. There is more than a usual amount of motion, and I consider the result rather better than we generally expect. As a rule, "flail" joints result from excision and the arm is not very useful; here, however, while the joint is not at all strong, it has most of the normal motions. While the elbow was healing, he complained of pain in the upper part of the left thigh. Nothing could be found by superficial palpation, but on deep palpation a dis-

tinctly fluctuating mass could be outlined. This I concluded was a tuberculous abscess whose origin was unknown. I aspirated, thus removing a considerable amount of pus, and the abscess remained empty. I can find no bone lesion that could explain this. I think it was merely a tuberculous focus in the soft tissues of the thigh, the growth of which eventually produced the abscess cavity. There has been no recurrence, but the young man complains of pain in that region on damp days."

SARCOMA OF FIBULA.

A skiagraph of a sarcoma of the fibula was exhibited by Dr. Sherman, who said: "The patient presenting the condition which is here represented in shadows by means of the X-rays, gave the following history: About five or six months ago she commenced to feel pain in the region of the right popliteal space. Later some thickening was noticed and the pain increased in severity and extended down the leg toward the ankle and toes. I first saw her two weeks ago. I found the upper part of the leg tense and tender. No variation could be felt in the resistance offered to the sense of touch; it seemed to be evenly tense at all points. There was no temperature and no history of any traumatism. The diagnosis seemed to lie between tuberculosis and sarcoma. The X-ray picture shows a condition that does not correspond with any X-ray picture of tuberculosis in bone that I have seen. The fibula has a peculiarly fragmented appearance; the lime salts have been entirely absorbed at some points, while at others their partial absorption has given the bone the appearance of fragmentation already mentioned. I have looked for an X-ray picture of sarcoma, but without finding one; Dr. Jones, who made this skiagraph for me, has not before made an examination in bone sarcoma and has no plate of such a condition. The clinical picture, together with the appearance of the skiagraph, leads me to believe that I shall find, on operation, a sarcoma."

Dr. Thos. W. Huntington: "I can only commend the result as a most unusually satisfactory one. It shows what can be done in these conditions which looks so unpromising. I think I may safely say that it is the best result after resection at the elbow joint that I have ever seen. We have all seen many flail joints, but one seldom sees a joint with such good function. As the result of my later experience, I must say that I do not like prolonged packing. I think we have all been packing wounds for too long a time, and that many of them will heal much more quickly if this period of packing is made shorter. After the cavity is clean the pack simply acts as a foreign body and is an irritant. This I think is particularly true when we are dealing with the shafts of bones, as in osteomyelitis. I did not see this patient at the time and do not doubt that the prolonged packing was necessitated by the condition presented. We know that much injury may be done to a

nerve and its functional activity remain, but it is certainly interesting to know that the carbolic acid with which this ulnar nerve was bathed did not affect it harmfully."

Dr. Dudley Tait: "I have never seen a better result follow resection of the elbow joint. The packing of wounds is generally a matter that depends upon the observed conditions. When the wound is clean, it closes. I think it would be well to carry into general surgical work the methods which we employ in dealing with septic conditions of the gall bladder. Here the wound is kept open till the discharge is found to be aseptic, when it is closed. In regard to the result, I should like to ask Dr. Sherman if much of the humerus was removed?"

Dr. Sherman: "All of the epiphysis was removed. About one and one-half inches, including both condyles."

Dr. Huntington: "I recall a case in which the operator inadvertently irrigated the wound with almost pure carbolic acid. The acid was placed in bag of the fountain syringe in which the proper amount of water to make a 2½ per cent solution had already been placed. The mixture was not good, and when the stream was turned into the wound, almost pure carbolic came from the irrigator. The wound surface was pretty well seared, but no harm resulted."

Dr. Harold Brunn asked whether anesthesia was observed after the operation reported by Dr. Sherman.

Dr. Sherman: "No."

Dr. Brunn: "Then the axis cylinder was not injured and of course, such being the case, no harm would be done to the nerve."

Dr. Henry Kreutzmann: "I am surprised to hear that modern surgeons are still using carbolic acid, when we have so many things that are better. I thought carbolic acid had been quite abandoned. In regard to wound packing, the packing of any wound will depend upon the clinical course of that particular wound, and no rules can be formulated to govern the question."

Dr. Sherman: "We pack a wound because the wound is not clean and in such shape as to close. While there remains the slightest amount of tuberculous infection it will not close, and we must keep it well drained and looked after. No matter how hard we may try to make such a wound close, it will not do so. On the other hand, when the wound has become clean and aseptic, we cannot keep it open; in 24 hours the packing will have been lifted up in the wound, which will have closed to some extent below the packing. In this way wounds close rapidly, in spite of the packing, when they have become clean. In regard to the use of carbolic acid, I have certainly found it extremely useful. It is, as we well know, not an acid at all, but an alcohol. Ethyl alcohol will antidote the effects of phenyl alcohol (carbolic acid), if the latter be diluted with the ethyl alcohol before it has remained in contact with the tissues for two

minutes. We may even wash the hands with pure carbolic acid, if we subsequently, and within two minutes, rinse off the carbolic with alcohol. At the Children's Hospital I am now having all dressings made with sterilized rubber gloves on the hands and the amount of suppuration has much lessened. I am having carbolic acid, $2\frac{1}{2}$ per cent solution, used on one floor and salt solution on another floor, and I can see no difference. When I am a little more certain of this fact I shall abandon the use of the carbolic acid altogether and use salt solution. The thorough asepsis of the hands, secured by using sterile rubber gloves, is the great thing."

PSEUDOMYXEMATOUS DEGENERATION.

Dr. Henry Kreutzmann presented a specimen of pseudomyxematous degeneration of the ovary, portions of the peritoneum, tube, etc. The specimen had been removed two weeks before. He recalled the recorded cases of this peculiar condition, some thirty or forty in number, laying stress on the fact that practically all had died within a year or two after the operation, apparently from subsequent involvement of the whole peritoneum with growths of a similar character. In some of the cases the tumor had ruptured and the sticky contents were found in the abdomen; in others the sticky mass was allowed to escape into the peritoneal cavity at the time of operation. In all, general degeneration of the pseudomyxematous variety followed.

Dr. Kreutzmann said: "I recall a case which I saw in 1896. The patient was a German woman who had previously been well. I found a small tumor of the right ovary and decided to operate. There were no adhesions. I introduced a trochar, but nothing came through it. I then withdrew the trochar, and from the wound came some of the thick, sticky, colloid material which I at once recognized. I was extremely careful not to get any of this material into the peritoneal cavity. Two years ago the patient came to me again. The belly was very much distended and she was in poor health. On operation I found the entire peritoneal cavity studded with these tumors. I am of the opinion that in this case the infection of the peritoneum did not occur at the time of operation, but that the cause that produced the first tumor, gave rise to the subsequent general infection of the peritoneum. Two explanations are offered to account for these recurrences. First, that the colloid masses act as irritants and produce the degeneration; second, that the colloid masses escape from the tumor, adhere to the peritoneum and produce degeneration by infection. I am rather of the opinion that one cause produces both the first tumor and the subsequent tumors. Two weeks ago I operated upon another such patient. The woman was 47 years old, has seven children, the last being born three years ago. She was exceedingly fat, but had noticed that her belly was getting larger for the previous few months. She had menstruated regularly,

however, and therefore was doubtful that she was pregnant. I could make out a tumor, but on account of her size could not exactly locate it. She also had a large umbilical hernia. A large incision was made, and an exceedingly large tumor of the right ovary discovered. The umbilical hernia consisted of omentum and some small tumors, which, together with the ovarian tumor, were of this pseudo myxematous variety. The main tumor was immense in size, but I was very careful to remove it without getting the contents, this colloid material, into the peritoneal cavity. Careful examination of the tumor masses removed shows the tumor of the ovary to be myxedamatous in part and fibromatous in part the tumors removed with the umbilical hernia are myxedamatous the tumors found on the mesentary are myofibromata. In places the tumors look very much like sarcomatous growths.

Dr. J. Henry Barbat: "I reported a case some four years ago, on which I had operated. I found the entire abdomen filled with this sticky mass, it had to be scooped out with the hands. There was a large ovarian cyst which had ruptured and part of the contents had escaped the remainder had to be scooped out. She did very well, however, and died three years later from tuberculosis of the lungs. I could not see that she was harmed by the presence of this material in the peritoneal cavity, and that certainly did not cause her death."

Dr. Tait: "I reported a case five years ago. The tumor was immense and peculiar in shape, looking very much like the intestines. There has been no recurrence."

PRIMARY CARCINOMA OF BONE.

Dr. Guido Caglieri reported a case as primary carcinoma in bone. He said: "The patient presenting this interesting condition came to me some two months ago. He was 52 years old, and gave no personal or family history. He complained of some pain in the neck and said a tumor had appeared there a few months before and was growing. The anterior and posterior triangles were pretty well filled with what I thought to be simple enlarged, tuberculous glands. They were hard and connected. I examined the man very carefully, but could discover no malignant growth. It was decided to operate and clean out these glands, because one of them had broken down. At the time of operation the possibility of their being secondary to some malignant growth elsewhere was mentioned, but nothing of the sort could be found. The patient did fairly well for a couple of days, then grew worse. At the end of a week the entire region of the operation was enormously enlarged and the appearance of the wound and skin showed clearly that the mass was cancerous. He died in the sixth week following the operation and the post-mortem examination revealed a most peculiar condition. Springing from the sixth rib, and protruding into the lung, is a large mass. The

glands of the mediastinum, the neck, and in fact, in the whole vicinity, are cancerous. A section removed from the mass near the site of the operation shows every appearance of carcinoma."

Dr. Philip King Brown: "While primary carcinoma of bone is so extremely rare as to, in every case, lead to some doubt and enforce a most careful examination, I am of the opinion that we have here a case of primary carcinoma of bone. The mass is exceedingly hard, there are cells of many kinds to be found in it, and there is a good deal of stroma, giving hardness to the mass. We find epithelial cells and glucocytes in large numbers. In some places the section seems to look more like sarcoma, but as a whole it has the appearance of being carcinoma."

Dr. Douglass W. Montgomery said: "I must say that it does not appear to me a carcinoma. I think it has more the appearance of a form of sarcoma."

Dr. Brown said: "The clinical picture, taken in conjunction with the section, leads me to believe it carcinoma. The mass, weighing five or six pounds, grew in six days; as you see, it is a hard mass, while we know sarcomata are softer. I grant that if we consider a few places only, it does not look like carcinoma, but if the whole section is examined and an opinion based upon the condition of the section entire, it has more the characteristics of carcinoma. In many respects it resembles an endothelioma. The section is rather thick and for that reason we cannot get so clear a picture as could be desired."

Dr. Tait: "I am inclined to believe the mass a carcinoma, primarily of the sixth rib. The exceedingly rapid growth of a hard mass of this character, is certainly a point that must be considered in forming an opinion. The history of the case enforces upon us the fact that it is unwise to do any incomplete operation for cancer."

TUBERCULOSIS OF THE EPIDIDYMIS.

Dr. Dudley Tait exhibited a specimen of tuberculosis of the epididymis. The specimen was a testicle which had been removed for the cause named. Dr. Tait stated that he did not think it right that the Academy should adhere to the opinion, expressed at a previous meeting and published, that radical surgical methods alone should be employed in dealing with this condition. He thought that as the testicle is a gland with internal secretions of value to the individual economy, it should be preserved when possible. The specimen showed that the epididymis alone was involved and the testicle itself might have been saved.

Book Reviews.

THE SURGICAL DISEASES OF THE GENITO-URINARY TRACT, VENEREAL AND SEXUAL DISEASES. A Text-book for Students and Practitioners. By G. Frank Lydston, M. D., Professor of the Surgical Diseases of the Genito-Urinary Organs and Syphilology in the Medical Department of the State University of Illinois; Professor of Criminal Anthropology in the Kent College of Law; Surgeon-in-Chief of the Genito-Urinary Department of the West-Side Dispensary. Fellow of the Chicago Academy of Medicine, etc. Illustrated with 233 Engravings, 6½x9¾ inches. Pages xvi--1024. Extra Cloth, \$5.00, net. Sheep or Half-russia, \$5.75 net. The F. A. Davis Co., Publishers, 1914-16 Cherry St., Philadelphia.

A new work on Genito-Urinary diseases in English and by an American author, has come to our reviewing table. It is arranged with the object of facilitating reference, and the matter is so ably condensed that it is a pleasure to obtain the necessary or desired information.

The engravings are mostly copies from some other work, but all are well chosen and suffice to illustrate the text.

This volume is practical, thorough, late, and gives a satisfactory survey of the entire field of genito-urinary and venereal diseases as seen by the general practitioner as well as by the syphilographer.

Nothing is lost by the author's own ideas of the management of cases of this description.

The chapters on "Urethritis" and "Stricture" are interesting in the extreme and present the all-important points of treatment in a thorough manner. As well, the chapters on "Diseases of the Prostate" with the author's divisions of the subject, contain all that is late and satisfactory in the management and successful handling of these troublesome cases.

Diseases of the kidney with the best and latest appliances for diagnosis of such pathological processes are given in able and clear manner, and the portions of the sections devoted to treatment are full of worth. All in all, the book is one needed by those who wish to keep abreast of the times in the various phases of this important branch of medicine.

THE ARISTOPHILON. A Nemesis of Faith, by Frank D. Bullard, A. M., M. D., Los Angeles, Cal. R. R. Donnelley & Sons Company, Chicago, 1899.

Occasionally one of the followers of Galen lays aside his arduous duties in the profession, and, mounting his Pegasus, soars to realms of poetic license and rhythmic beauty. At such times he is none the less a busy toiler for the health and happiness of his patients, for many of the finest gems of thought are

discovered and clothed as he makes his way to a bedside of pain, or as he sits beside a soul just about to enter the "covered bridge" which leads to the farther side of the deep, dark River. Many of the noble men in the great profession of medicine have given of their time and talents to writing. Such men as S. Weir-Mitchell, and more lately, John Wyeth, in his historical sketches, have done not a little to stimulate a love of letters in their professional brethren. Both of them have written classics in their respective classes of literature.

One of the leading physicians of the State of California has recently joined the forces of the literatures and has augmented the wealth of verse with a noteworthy addition. The physician is Dr. Frank D. Bullard, and the volume is entitled "The Aristophilon."

As the "disbeliever," "doubter," "devotee," the writer gives his various arguments for all, as he is or has been all three in his life. Here is a specimen of the thought and rhythm of his verse:

The Disbeliever says:

"From Ghost to God is but a narrow span,
In figment of the fancy both began,
As man grows wiser, nobler is his God,
God's but 'the shade cast by the Soul of man.'"

The Doubter says:

"As well to quench the thirst at painted pool,
Or try the hot and sweaty brow to cool
In mimic shadow of a pictured wood,
As satisfy with such a God the soul."

Other charming lines will repay the reader through the hundred and almost a half stanzas.

The epilogue reads thus:

"So long I parry arguments with skill,
And pros and cons consider at my will;
The great Enigma that e'er racks the brain
Cannot be solved by man, until—until?"

INTERNATIONAL CLINICS. "A Quarterly of Clinical Lectures on Medicine, Neurology, Surgery, Gynecology, Obstetrics, Ophthalmology, Laryngology, Pharyngology, Rhinology, Otology and Dermatology," and Specially Prepared Articles on "Treatment and Drugs." By Professors and Lecturers in Leading Medical Colleges of the United States, Germany, Austria, France, Great Britain and Canada. Edited by Judson Daland, M. D., Philadelphia, Instructor in Clinical Medicine and Lecturer on "Physical Diagnosis" in the University of Pennsylvania; Assistant Physician to the Hospital of the University of Pennsylvania; Professor of Clinical Medicine in the Philadelphia Polyclinic; Fellow of the College of Physicians of Philadelphia. Volume I, Ninth Series, 1899, Philadelphia. J. B. Lippincott Company, 1899.

Volumes I and II of the International Clinics are ready for the reader, and as usual with these publications, the numbers of April

and July are replete with articles of interest from the pens of such men as John Ashhurst, Jr., M. D., LL. D., Philadelphia; Adolf Baginsky, Berlin; John B. Hamilton, M. D. LL. D. (the late) of Chicago; A. J. C. Skene, M. D. LL. D., Brooklyn; Horatio C. Wood, M. D. LL. D., Philadelphia; William L. Rodman, A. M., M. D., Louisville; E. Quenu, M. D., Paris, and others equally notable among the names great in medical literature. Papers from such men as the following give strength and interest to the second volume: L. Brocq, M. D., Paris; Charles Greene Cumston, B. M. S., M. D., Boston; Alfred Fournier, M. D., Paris; Virgil P. Gibney, M. D., New York; A. E. Halstead, M. D., Chicago; H. A. Hare, M. D., Philadelphia; Professor Lassar, Berlin, and besides these the pages are full of excellent material from men fully as prominent as those mentioned.

In Volume I the articles on "Treatment of Tuberculosis," by Professor J. Grancher; "The Treatment of Burns," by William C. Dugan, M. D.; "The Valvular Diseases of the Left Heart," by J. N. Hall, M. D.; "A Rational View of the Appendicitis Question," by John B. Roberts, M. D.; "Hernia in Children; A Plea for Radical Cure as Routine Practice," by Robert William Parker, M. R. C. S. (England); "Flickering Before the Eyes," by Professor Silex; and in Volume II. "The Treatment of Carbuncles and Furunculosis by Beer Yeast," by L. Brocq, M. D.; "The Roentgen Ray Diagnosis of Renal and Vesical Calculous Conditions," by Charles Lester Leonard, A. M., M. D.; "Paranoia," by George L. Sinclair, M. D.; "The Necessity for the Early Recognition and Prompt Removal of All So-called Benign Tumors in the Female Breast," by William J. Taylor, M. D.; "Cholecystotomy, Neurectomy, Thoracoplasty," by William M. Harsha, M. D., will all well repay careful reading and study.

The numbers still present the same form and style as the previous ones, and are equally well printed and illustrated.

So far this series has proven itself to have a place in essentially medical publications, and if the standard is maintained, they will continue to add laurels to the editor and writers and knowledge to the increasing number of readers.

ITEMS.

Dr. F. L. Adams has removed his office from 12th and Broadway to 14th and Broadway, Central Bank Building, Oakland. Hours 10 to 11 a. m., 4 to 5 p. m.

Dr. Winslow Anderson has removed his office from 1220 to 901 Sutter Street, San Francisco.

Dr. J. Dennis Arnold has removed his office from 536 Sutter Street to 1296 Van Ness Avenue.

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SOL. HYPOPHOS. C. P.

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That Codeine had an especially beneficial
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was capable of controlling excessive cough-
ing in various lung affections, was noted be-
fore its true physiological action was under-
stood. Later it was clear that its power as a
nerve calmative was due, as Bartholow says
to its special action on the pneumogastric
nerve. Codeine stands apart from the rest
of its group, in that it does not arrest secre-
tion in the respiratory and intestinal tract.
In marked contrast is it in this respect to
morphine. Morphine dries the mucous mem-
brane of the respiratory tract to such a degree
that the condition is often made worse by its
use; while its effect on the intestinal tract is
to produce constipation. There are none of
these disagreeable effects attending the use of
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The coal-tar products were found to have
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long before experiments in the therapeutical
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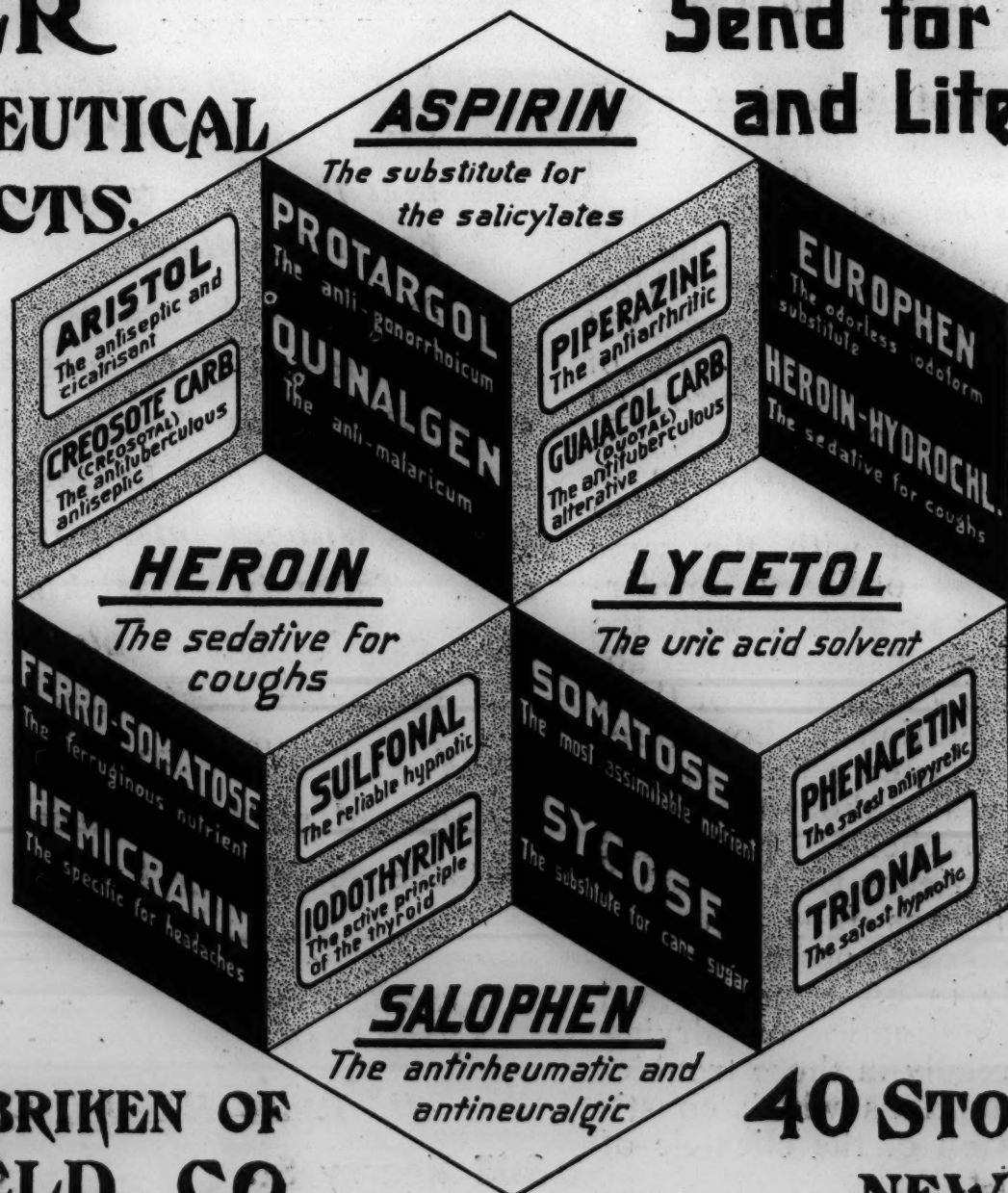
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THE TREATMENT OF LACERATED CERVIX.

Dr. G. H. Thompson, of St. Louis (American Journal of Surgery and Gynecology, September, 1899), reports a case of neglected lacerated cervix with extensive granulating surfaces around the os uteri, in which the following treatment proved successful. After giving a vaginal douche he carefully washed out the uterine cavity, and taking a strip of plain aseptic gauze sprinkled it with euophen powder and introduced it into the uterus, cutting off the end which protruded from the os. The granulating surfaces of the laceration were then carefully dusted with the same powder by means of an ordinary powder-blow, and the vagina was packed with the same improvised euophen gauze and absorbent cotton. The daily repetition of these dressings healed the laceration in about three weeks; the endometritis lasted a little longer, but quite speedily got well without the necessity of curettage or a trachelorrhaphy. The author's subsequent experience with euophen convinced him that it was fully equal to iodoform in local therapeutic power, and he now uses it exclusively in his gynecological work whenever an antiseptic or drying powder is needed—especially in those troublesome inflammatory conditions which constitute so large a proportion of the clientele of the average gynecologist.

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Liquid Antipyretic (Tilden's), 3jss.

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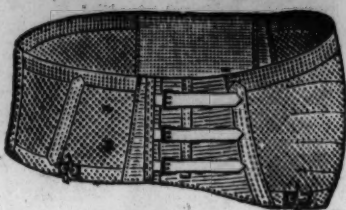


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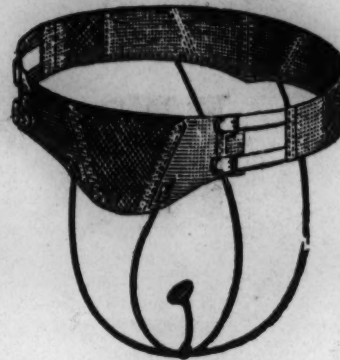


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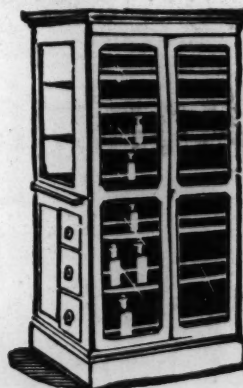
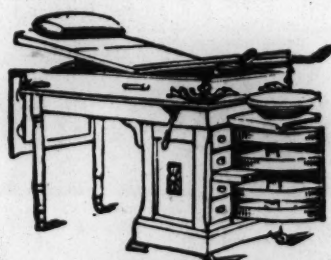
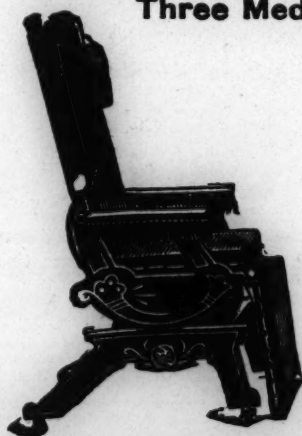
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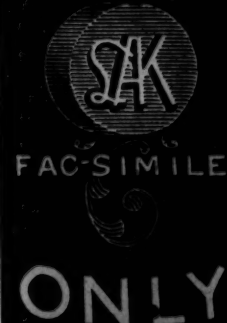
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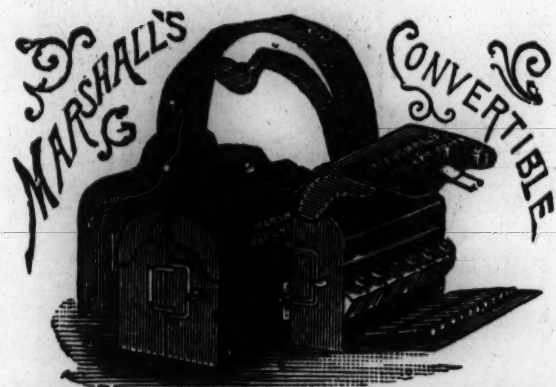
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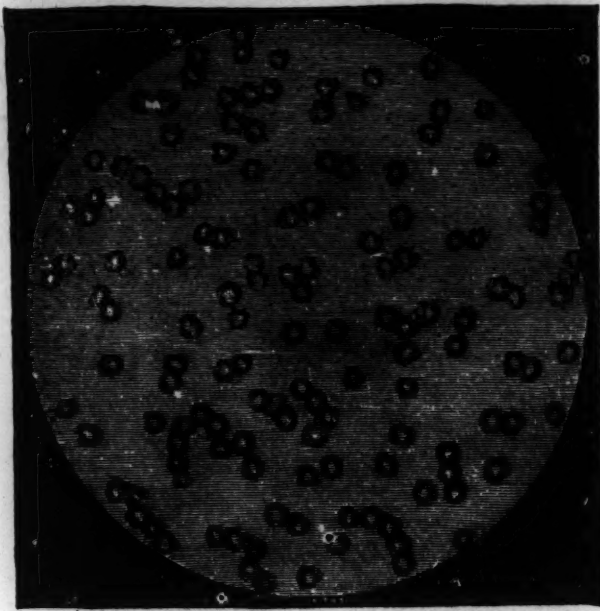
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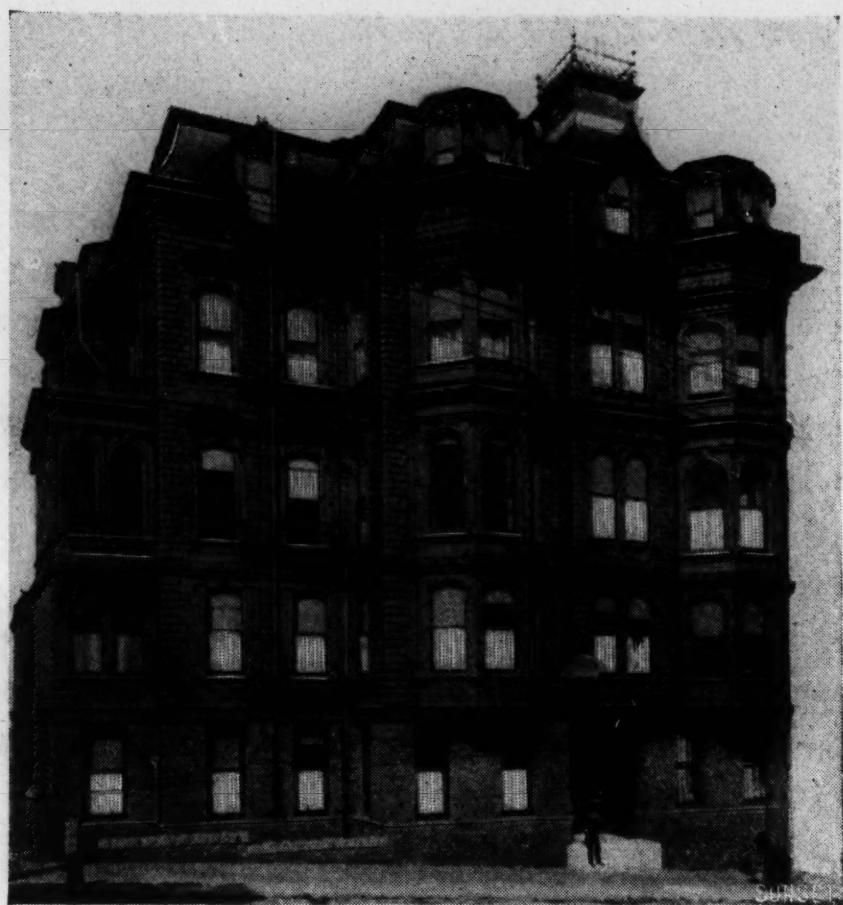
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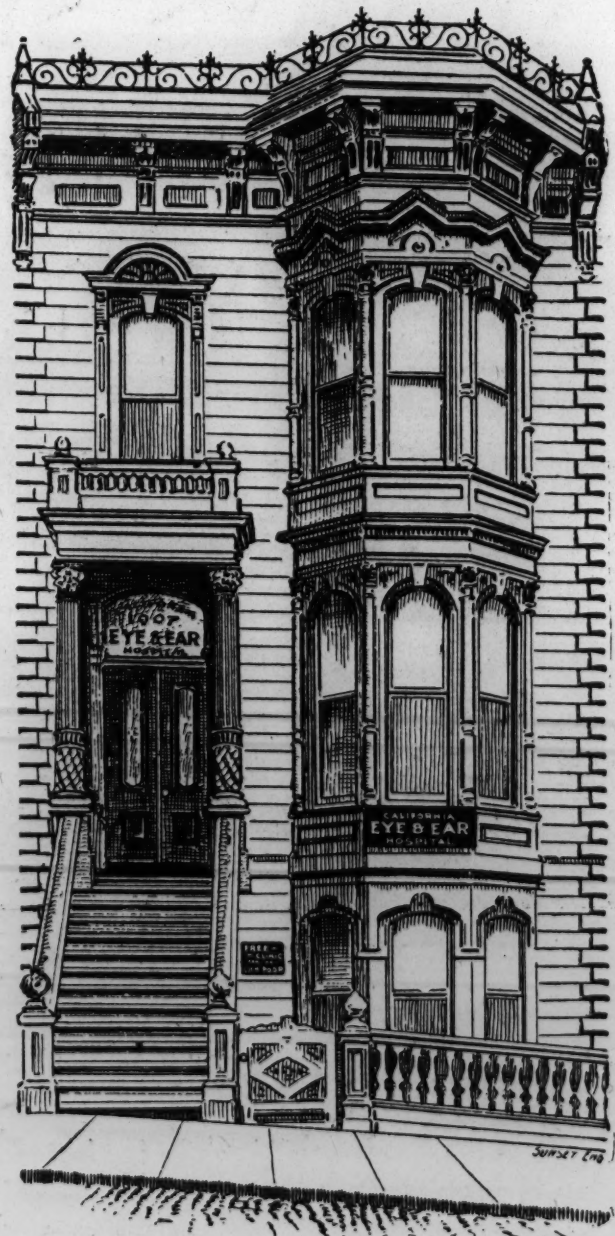
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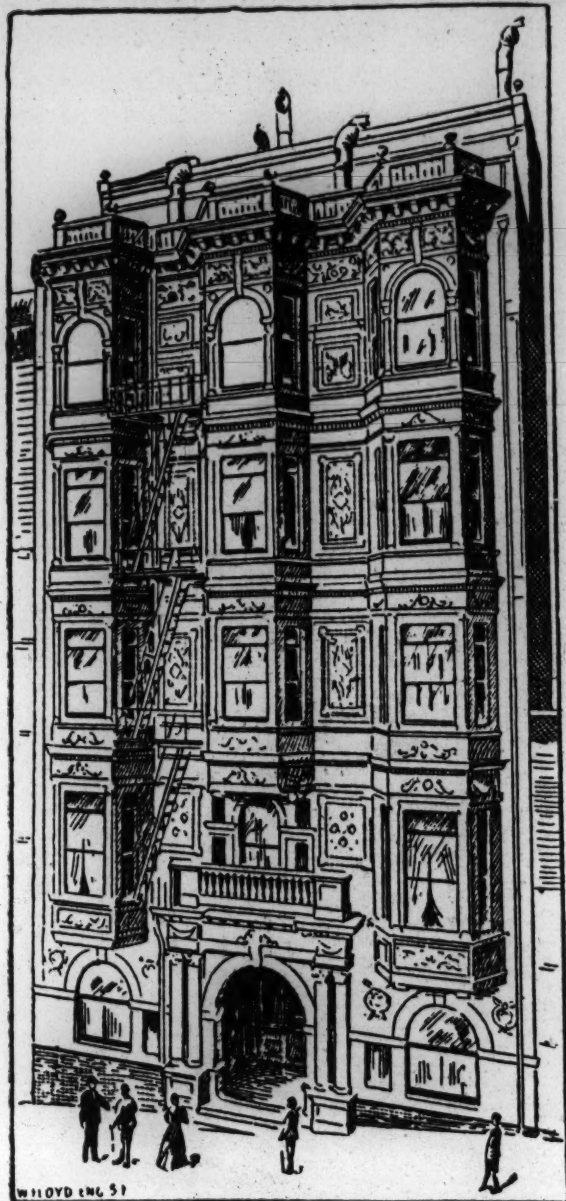
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